MEDICARE BALANCED BUDGET ACT REFINEMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

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MEDICARE BALANCED BUDGET ACT REFINEMENTS

FRIDAY, OCTOBER 1, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
September 24, 1999
No. HL–10

CONTACT: (202) 225–3943

Thomas Announces Hearing on Medicare Balanced Budget Act Refinements

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on refinements to the Medicare provisions included in the Balanced Budget Act of 1997 (P.L. 105–33). The hearing will take place on Friday, October 1, 1999, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Medicare provisions in the Balanced Budget Act of 1997 (BBA) contained more than 300 provisions related to the programs administered by the Health Care Financing Administration (HCFA), and represented the most extensive Medicare reforms since the enactment of the program in 1965. Among the positive changes were Medicare's expanded coverage of preventive benefits, additional choices for seniors through the new Medicare+Choice program, new tools to combat health care waste, fraud and abuse, and many initiatives to modernize and strengthen Medicare's fee-for-service payment systems. New payment methodologies were established affecting virtually every segment of the health care industry including managed care plans, hospitals, skilled nursing facilities, and home health agencies.

In many cases, however, HCFA has missed deadlines for implementing policies or developed policies in need of refinement. In addition, meeting the year 2000 computer challenges has continued to create a series of delays for HCFA in implementing the remaining major payment systems and changes required by the BBA.

In announcing the hearing, Chairman Thomas stated: "When this landmark legislation was adopted in 1997, Congress relied on the data and estimates available at the time, and expected the Administration to provide us with the necessary monitoring and feedback on the operation of these reforms. Not unexpectedly, with sweeping legislation that makes major revisions in Medicare payment policies, some refinements are needed. This refinement process should be a shared responsibility between the Administration and Congress. Where changes can be made through administrative action, the Administration should make them. Where it is necessary to make legislative changes, Congress should certainly do its part to make sure beneficiaries receive the health care services they depend on."

FOCUS OF THE HEARING:

The hearing will provide the opportunity to hear from the Administration, Congressional advisory bodies, and providers about the implementation, impact, and proposed refinements to BBA policies.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, with their name, address, and hearing date noted on a label, by the close of business, Friday, October 15, 1999, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, typed in single space and may not exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. Good morning. A little over 2 years ago, the Congress and the Administration reached agreement on the most extensive changes to the Medicare program since its inception in

1965. Among the improvements were Medicare's expanded coverage of preventative benefits, additional choices for seniors through the new Medicare+Choice program, new tools to combat healthcare waste, fraud, and abuse and initiatives to modernize the future of the fee-for-service portion of the program.

When we crafted this legislation, Congress relied on the data in the estimates available at the time. We expected the administration to provide us with the necessary monitoring and feedback on the operation of these reforms and the measuring tools that were to be provided. Since August 1997, the administration has implemented many of the more than 300 changes to the Medicare program. In some cases, however, the Health Care Financing Administration has missed deadlines for implementation or has developed policies, but some of those policies we now are coming to realize lack the necessary refinement.

In addition, their stated Year 2000 computer problem has produced a series of delays for HCFA in implementing the remaining major payment systems and changes that we agreed upon in the Balanced Budget Act. Not surprisingly, when legislation makes sweeping changes in payment policy, we need to go back and make corrections and refinements.

Today we are going to explore the impact to date of the Balanced Budget Act on health care providers and, ultimately, beneficiaries in an attempt to identify any refinements that need to be made to the Balanced Budget Act so that seniors continue to receive the highest quality health care and taxpayers get value for their tax dollars.

The goal of this hearing is to examine reforms, not repeal of the landmark Balanced Budget Act of 1997. The adjustment and refinement process should be, in my opinion, a shared responsibility between the administration and Congress. After all, both Congress and the President worked together to enact this historic legislation. It is only right that we now work together to perfect, to refine it and modify it. Where changes can be made through administrative action, we would hope that the administration would make them. Where it is necessary to make legislative changes, then Congress should certainly do its part.

This morning I am anxious to hear what steps the Health Care Financing Administration specifically has in mind to address those Medicare payment areas where they can act administratively. Today, I want to hear what the administration can do, and probably more importantly, what it is willing to do. Hopefully, they are one and the same so that we can ensure a vibrant health care system for all of our Medicare beneficiaries. Clearly, our Nation's seniors should get no less.

This morning we have witnesses from the administration, our policy experts from the Medicare Payment Advisory Commission, the General Accounting Office, and we will hear from a group of providers who wish to discuss from their particular point of view the Balanced Budget Act and how it has had an impact on their particular area of the health care delivery service to seniors. I look forward to a full and spirited exchange on suggested refinements. And prior to that, I would call on my colleague from California, the Ranking Minority Member, Mr. Stark.

Mr. STARK. Well, thank you, Mr. Chairman, thank you for holding this hearing. You are quite correct, there is much to be actually proud of in the Balanced Budget Act. It did away with a lot of fraud, it extended the life of the medicare trust fund to 2015 from 2001—the second longest extension of solvency in the program's history—and it showed that HCFA (or Medicare) could be a good purchaser.

Now, while it did a lot to stop unfettered growth in certain areas, there are places—I think we all agree—where there were excessive or unwise cuts. The $1,500 cap for rehabilitation has resulted in patients' care being underpaid. That is one of the problems I think we all agree need to be fixed.

On the other hand, I think we have to be careful about give-backs and not get panicked into trying to douse this conflagration with buckets of money. Every dollar that we give back raises the Part B premiums on seniors or reduces the solvency of the trust fund. And unless we pay for the Part B give-backs, we are dipping into the Social Security surplus. So we just don't have a lot of funds available to us and we have to be very careful to see that this package is paid for.

Over the next 30 years, as the Chair knows, we are going to need to make a combination of providers' cuts, beneficiary cuts, and/or increased taxes. There is no other way. So I hope that we will be prepared as we go along in making our corrections to the Balanced Budget Act to suggest how we anticipate paying for them, either now or in the future.

Now, finally, we as legislators always have to get grumpy with the executive, whether it is our executive or it is the opposition's executive department. But a lot of Members today are blaming HCFA for basically enforcing laws that we wrote. And I don't think we can say, "Hey, I wrote the law, but you guys ignore it". I think that we have to be willing to not play Pontius Pilate and pretend that we had nothing to do with this. I would like to go back to my old school of goose and gander, what-is-sauce-for-one-is-sauce-for-the-other school of politics, and say I too would like to hear from the administration exactly what they intend to do and what they recommend be done: No. 1, what they are going to do administratively, what they think they can do? No. 2, what they would like us to do in the way of making legislative changes?

But I would also ask the Chair if he would care to inform us about the upcoming schedule. I understand we are going to mark up something, sometime next week, and I wonder if the Chair could give us some idea of when that is scheduled. The rumors are coming that we are going to markup on Monday. When we might expect to see what our part of the bargain is going to be? If we get the administration to come up today with what they want, when are we going to do our part and what are we going to do? I yield to the Chair.

[The opening statements of the Hon. Fortney Pete Stark and Hon. Jim Ramstad follow:]

Statement of Hon. Fortney Pete Stark, a Representative in Congress from the State of California

Mr. Chairman: Thank you for holding this hearing. There is much to be proud of in the Balanced Budget Act. It created new prospective payment systems, fought

fraud, and helped extend the life of the Part A Trust Fund from 2001 to 2015—the second longest extension of solvency in the program's history. The BBA showed that Medicare could be a good buyer.

Pre-BBA, costs were clearly out of control and everyone was saying "what a terrible buyer Medicare is compared to the private sector." Home health spending was going up $2 billion a year, even though the number of Medicare beneficiaries was fairly flat. CBO predicted that between 1996 and 2003, home health spending would double from about $16 billion to about $32 billion. Between 1994 and 1997, 883 new home health agencies opened in the State of Texas alone—an 85% increase—and those receiving home health care were getting an average of 134 visits, compared to a national average of 69 and 30 in the State of Washington.

Same in nursing homes. Payments were going up $2 billion a year, quadrupling from about $3 billion in 1990 to $12 billion in 1997—and predicted to double to $24 billion by 2007.

These growth rates were simply unsustainable—especially since we have not even begun to deal with the impact of the retirement of the Baby Boomers.

We cannot return to those rates of inflation—and even with the new, March, 1999 CBO baseline, Medicare spending will double over the next ten years, although there will be little growth in the number of beneficiaries.

As for hospitals, many of them are losing money on managed care contracts and are asking Medicare to bail them out of bad contracts. Is it Medicare and the taxpayers' job to make hospitals whole on below cost private sector deals driven by the excess bed capacity in most markets?

While BBA did much to stem unfettered growth in certain sectors, there are places where the BBA made excessive or unwise cuts. The $1500 cap on rehab comes to mind. Care for some of the sickest SNF patients is underpaid. These problems need to be fixed.

But we need to be careful about the give-backs. The GAO and MedPAC will report that there is little hard evidence that the sky is falling or that we should be panicked into dousing providers with new buckets of money.

Every dollar we give back will raise Part B premiums on seniors or reduce the solvency of the Part A Trust Fund. And unless we pay for the Part B give-backs, we will hurt the Social Security surplus, that we are all pledging not to spend.

In the next 30 years the number of people on Medicare will double. To fund the program, we will need to make a *combination* of provider cuts, beneficiary cuts, and increased taxes. There is no other way. So, Mr. Chairman, as we proceed to "give back" some of the BBA, we make meeting the future challenges more difficult. Therefore, I hope the Members will be prepared to suggest ways to pay for the future of the program.

Finally, as legislators, we are often grumpy when Executive Branch agencies do not follow the laws we write. There are a lot of Members blaming HCFA for enforcing the laws we have written—and that's kind of strange: Members are saying "I didn't mean it; please ignore the law." If we don't like what HCFA is doing, let's change the law, and be willing to pay for it. But let's don't play Pontius Pilate and pretend we had nothing to do with the BBA and extending the life of Medicare Part A to 2015.

Statement of Hon. Jim Ramstad, a Representative in Congress from the State of Minnesota

Mr. Chairman, thank you for calling this important hearing to discuss changes to the Medicare provisions in the Balanced Budget Act.

As I stated on the House floor on Wednesday, I am really looking forward to this hearing today so that we might flush out some of the problems currently facing Medicare providers and beneficiaries.

As we all know, whenever you pass legislation of the historic magnitude of the Balanced Budget Act, there are bound to be unintended problems that will need to be addressed. Certainly, any problematic situations that have arisen due to the actual bill language we passed should be addressed with new, better bill language.

But Mr. Chairman, complications that are a result of the way in which the Administration has chosen to implement the laws we passed should and must be fixed by the Administration.

I consider myself a reasonable Minnesotan, and I can understand that HCFA may have trouble dealing with the massive legislation we passed. But that really isn't the major concern I have today. Today, I am frustrated with the way in which

HCFA bureaucrats are handling things—the way in which they obfuscate the laws we pass and slough off responsibility on Congress whenever they feel like it.

Mr. Chairman, I plan to ask HCFA some tough questions today on behalf of all the Medicare beneficiaries in my State. I don't want to hear excuses about "prescriptive" bill language or evasive responses.

Thanks again, Mr. Chairman, for calling this important hearing. I invite the Administration to join me and the Members of this Subcommittee, for the sake of seniors across our great nation, in seriously and responsibly addressing the concerns and problems that are occurring in the Medicare program.

Chairman THOMAS. I thank the gentleman. Operative word in all of this is "if." clearly, as I indicated in my opening statement, that we went into this together, I think positively, and we ought to continue to work together. What the administration can do means it is something that Congress doesn't have to do. There may be a difference between what the administration can do and what the administration will do. To the degree that they believe that there is any statutory provision which is unclear and which they wish clarified in terms of their responsibilities, I think it is also incumbent upon us to perhaps indicate that we think they have the ability, that congressional intent can be conveyed so they could again make adjustments.

One of the key abilities that the administration would have would be to soften the impact of some policies which in the abstract we believe to be appropriate, but perhaps the time lines are not appropriate, and you could stretch out some time lines, you could make some adjustments. You could take some payments that would otherwise be removal of money from a particular area and create a budget-neutral payment structure.

I believe the administration in their testimony will indicate that they believe they can do in this particular areas. We probably believe they can do it in more areas than they indicate, and where we need to clarify that we would clarify it.

Let me explain to the gentleman and others what I consider to be our basic rules in approaching what are to be adjustments in the Balanced Budget Act of 1997. So when you say adjustments, what we really mean are refinements, not repeal. I am frankly interested in our MedPAC testimony and our GAO testimony which continues, as did the Inspector General of the General Accounting Office last week in essence, to pat us on the back for sticking to the program that we think as we make these refinements is a significant improvement over the old Medicare system. So we are not looking for repeals, we are looking for refinements.

In addition to that, although anecdotes are useful to illustrate some difficulties in particular areas, data is much better. We do think if you are going to get adjustments in particular areas you need to show costs, that there is a need. Pleading this probably isn't sufficient for us to make adjustments.

And then finally, we do need to look at this in terms of the immediacy of some of the changes that are necessary. A lot of times Congress looks at 5-year windows, the Senate and the administration sometimes looks at 10-year windows. I am more concerned with the impact over the next 6 to 9 to 12 months than I am over some indication that there may be an adjustment in the 2003, 2004

outyear period. So time lines that matter, I think, are critical as we make refinements; not repealing BBA 1997 based upon showing cost. Those will be the kinds of principles that we will be operating on.

I will tell the gentleman that I have asked the Congressional Budget Office to "score," as we say, a number of adjustments. There have been no lack of suggestions from this room and beyond as to changes that might be made. It is no secret, not difficult to compile a list of suggested changes. We are trying to get dollar amounts as best we are able and impact circumstances for those. We then kind of lay them out and look at what appears to be those changes that fit the criteria here, principles that I outlined.

I know that time is short. But the longer we have waited, the better information we have available, the better decision that we can make. The dollar amounts that the Congress would be responsible for will be in large part based upon the administrative adjustments the administration believes it can make. As we look at the burden between the both of us, I think we can make some useful and significant changes without a significant burden on the Congress in terms of actual dollars.

Let me also say to the gentleman that he mentioned the Social Security fund, or dipping into it. It seems to me that most people and the congressional statements that have been passed in regard to retirement security mentioned both Social Security and Medicare. I think most people believe that in making adjustments to these long-term security interests of seniors, that if it is necessary to spend some money in the adjustments of the Balanced Budget Act of 1997 in the area of Medicare, utilizing surplus monies for retirement security has a higher calling than most of the other demands that we have heard recently on those funds. That will be a decision that we will perhaps face. Our hope is that we would not have to face that decision, but it ought to be laid on the table at this time.

Mr. KLECZKA. Will the Chairman yield further?

Chairman THOMAS. Very briefly.

Mr. KLECZKA. The question from Mr. Stark was whether or not we were going to have a markup on some type of refinement bill next week.

Chairman THOMAS. I indicated I am waiting for the Congressional Budget Office to supply us with some numbers so we can actually have a decision matrix in front of us. I am not interested in making decisions on anecdotes; I am interested in making decisions on data. I cannot tell you when the markup will be because the Congressional Budget Office hasn't given me the information yet. I would have preferred to have done it last week, I would have preferred to do it this week, I prefer to do it next week.

Mr. KLECZKA. Is there a dollar amount that the House is working under or—the administration is talking about a $7 billion refinement; the Senate's Minority talk about 20. Do we have some type of a ballpark figure?

Chairman THOMAS. I would tell the gentleman the administration's number, as I understand it, is $7½ billion over 10 years. The Minority leader, since he isn't responsible for any of that, 20 billion over 5. I would tell the gentleman that somewhere between those

two numbers is an appropriate amount and we will arrive at that in due time.

Mr. KLECZKA. Super. Thank you.

Chairman THOMAS. I thank the gentleman. As is usually the case, if any member has written testimony, it will be made a part of the record.

And with that, Mr. Hash, the Acting Administrator of the Health Care Financing Administration, at the request of both the Chairman and the Ranking Member, and your testimony—if at all possible you could outline for us what the administration can do and what the administration will do, your written testimony will be made a part of the record. You may address us in any way you see fit in the time you have.

STATEMENT OF HON. MICHAEL HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. HASH. Thank you, Mr. Chairman. Chairman Thomas, Congressman Stark and other distinguished members of the Health Subcommittee, we want to thank you for inviting us today to discuss refinements to the Balanced Budget Act. The BBA reforms are critical to strengthening and protecting Medicare for the future. The Medicare Trust Fund, which was projected to be insolvent by 1999 when President Clinton took office in 1993, is now projected to be solvent through 2015.

It is clear that the BBA is succeeding in promoting efficiency and slowing the growth of Medicare expenditures and extending the life of the Medicare Trust Fund. We view that when we worked to develop the BBA, that we were partners with you, Mr. Chairman, and the rest of the committee. And as we observe any unintended consequences that require changes to the BBA, we want to call on and work together with you as partners.

We believe that it is important to recognize that the BBA is only one factor contributing to changes in Medicare spending. The Congressional Budget Office and our own actuaries have stated that substantial strides in fighting fraud, waste, and abuse in the Medicare program have reduced significantly the growth in outlays. In addition, low inflation from a strong economy is having an effect on Medicare spending rates. And slower claims processing during the transition to new payment systems is contributing to what we believe is a temporary slowdown in spending.

We are concerned about reports of the financial condition of some providers. But it is essential, I think, as we look at these reports to distinguish the BBA's impact from the effects of things like excess capacity in the system, discounted rates to other payers, aggressive competition in the health care system, in some cases imprudent business decisions and other factors not caused by the BBA.

And it is essential that we focus the impact on beneficiaries, ensuring that they continue to enjoy access to high-quality health care services.

Changes of the magnitude included in the Balanced Budget Act always require adjustments. We have been proactively monitoring the impact of the BBA on beneficiaries to determine what changes may need to be made to ensure continued access to high-quality

services. Thus far, our monitoring reveals evidence of isolated but significant problems. Although our analysis is not yet complete, we are concerned, for example, that some beneficiaries are not getting necessary care because of the Balanced Budget Act's $1,500 annual caps on certain rehabilitation therapeutic services.

We will continue working with beneficiaries, providers, the Congress, and other interested parties to closely monitor the performance of providers to evaluate the evidence of problems and access to quality care and to develop appropriate and fiscally responsible solutions.

Because of our concerns, as many of you know, the President's comprehensive Medicare reform plan sets aside a quality assurance fund of $7.5 billion over the next 10 years to smooth out the implementation of the Balanced budget payment reforms that may be adversely affecting beneficiary access to quality care. We would like to work with the Congress to make appropriate adjustments where there is evidence that adjustments are needed. The President's plan also includes administrative actions to assure a smooth implementation process that we have already taken, or that we are considering currently, in the context of pending rules.

We are working with Congress to identify appropriate and prudent legislative solutions. We are also taking several initiatives in our administrative discretion to help hospitals and home health agencies and other providers adjust to the changes in the BBA. For example, we are delaying the extension of hospital inpatient transfer policies to other diagnoses for a 2-year period.

We are considering, in the context of our rule on the outpatient hospital PPS system, delaying the volume control mechanism for the first few years of the new outpatient protective payment system. We are also considering a 3-year transition to the new hospital outpatient payment system by making budget-neutral adjustments to increase payments to hospitals that would otherwise receive large reductions, such as low-volume rural and urban hospitals, teaching hospitals, and cancer hospitals.

We are proposing to use the same wage index for calculating hospital outpatient PPS payments that is used for the inpatient protective payment system. And finally we are trying to make it easier for rural hospitals whose patients now are based on lower rural average wages to be reclassified and receive payments based on higher average wages in nearby urban areas and thus receive higher PPS payments.

To help home health agencies, we are increasing the time for repayment of overpayments related to the interim payment system from 1 year to 3 years, with 1 year interest free. We are also following the recommendations of the General Accounting Office by requiring all home health agencies to obtain surety bonds of only $50,000, not 15 percent of their annual Medicare revenues as was proposed earlier.

We have eliminated the sequential billing requirement that many home health agencies indicated was contributing to cash flow problems, and we are phasing in our instructions to implement the requirement for home health agencies to report their services in 15-minute increments. We are also phasing in risk-adjustment for Medicare+Choice plans. And we have made several other refine-

ments to the Medicare+Choice regulations that strengthen protections for beneficiaries while making it easier for plans to participate. We are actively looking to see where we might be able to make additional accommodations to help plans and providers adjust to the BBA.

Let me say again, Mr. Chairman, that when we worked to develop the BBA, we viewed ourselves as partners with you and this committee. As issues arise that need to be addressed, we want to work together with you again as partners and we look forward to going forward to that task together.

I thank you for inviting us today and for holding this hearing. I would be happy to respond to questions that you or other Members of the Subcommittee may have. Thank you.

Chairman THOMAS. Thank you very much, Mike. I appreciate the spirit with which we are approaching this effort. I hope it remains through the entire process.

[The prepared statement follows:]

Statement of Hon. Michael Hash, Deputy Administrator, Health Care Financing Administration

Chairman Thomas, Congressman Stark, distinguished Subcommittee Members, thank you for inviting us to discuss refinements to the Balanced Budget Act. The BBA includes important new preventive benefits and payment system reforms that promote access, efficiency, and prudent use of taxpayer dollars. These reforms are critical to strengthening and protecting Medicare for the future. The Medicare Trust Fund, which was projected to be insolvent by 1999 when President Clinton took office, is now projected to be solvent until 2015.

The BBA made substantial changes to the way Medicare reimburses providers in the fee-for-service program by:

- modifying inpatient hospital payment rules;
- establishing a prospective per diem payment system for skilled nursing facilities to encourage facilities to provide care that is both efficient and appropriate;
- refining the physician payment system to more accurately reflect practice expenses;
- initiating development of prospective payment systems for home health agencies, outpatient hospital care, and rehabilitation hospitals that will be implemented once the Year 2000 computer challenge has been addressed; and,
- authorizing an important test of whether market competition can help Medicare and its beneficiaries save money on durable medical equipment and supplies.

And the BBA created the Medicare+Choice program, which allows private plans to offer beneficiaries a wide range of options, similar to what is available in the private sector today. It has initiated a new beneficiary education campaign to inform beneficiaries about these options. It includes important new protections for patients and providers, as well as statutory requirements for quality assessment and improvement. And it initiates a transition to risk adjustment, which will make the payment system fairer and more accurate.

We have fully implemented the majority of the BBA's more than 300 provisions affecting our programs and made substantial progress on the remainder. While the statute generally prescribes in detail the changes we are required to make, we are committed to exercising the maximum flexibility within our limited discretion in the implementation of these provisions.

It is clear that the BBA is succeeding in promoting efficiency, slowing growth of Medicare expenditures, and extending the life of the Medicare Trust Fund. However, according to both the HCFA actuaries and the Congressional Budget Office (CBO), the BBA is only one factor contributing to changes in Medicare spending. We have made substantial strides in fighting fraud, waste and abuse that have significantly decreased improper payments. For the first time ever, the hospital case mix index declined last year due to efforts to stop "upcoding," or billing for more serious diagnoses than patients actually have. Low inflation from a strong economy is having an impact on total spending. And slower claims processing during the transition to new payment systems is contributing to a temporary slow-down in spending. Backlogged claims are expected to be paid by fiscal 2000.

Change of this magnitude always requires adjustment. It is not surprising that some market corrections would result from such significant legislation. We are proactively monitoring the impact of the BBA to ensure that beneficiary access to covered services is not compromised. We are evaluating this information to assess the impact of BBA changes on beneficiaries and to determine what changes may need to be made to ensure continued access to quality care.

It is important to note that the BBA is only one factor contributing to challenges providers face in the rapidly evolving health care market place. Efforts to pay correctly and promote efficiency may mean that Medicare no longer makes up for losses or inefficiencies elsewhere. We are concerned about reports on the financial conditions of some individual and chain providers. But it is essential that we try to delineate the BBA's impact from the effects of excess capacity, discounted rates to other payers, aggressive competition, imprudent business decisions, and other factors not caused by the BBA. And it is essential that we focus on the impact on beneficiary access to high quality patient care.

Thus far, our monitoring reveals evidence of isolated but significant problems. Although our analysis is not yet complete, we are concerned, for example, that some beneficiaries are not getting necessary care because of the BBA's $1500 caps on certain outpatient rehabilitation therapies. We will continue working with beneficiaries, providers, Congress, and other interested parties to closely monitor the situation, evaluate evidence of problems in access to quality care, and develop appropriate, fiscally responsible solutions.

Because of our concerns, the President's Medicare reform plan sets aside $7.5 billion from fiscal 2000 to fiscal 2009 to smooth out implementation of BBA payment reforms that may be adversely affecting beneficiary access to quality care. We want to work with the Congress to make appropriate adjustments where there is evidence that adjustments are needed. The President's reform plan also dedicates a portion of the budget surplus to Medicare. This will help prevent excessive cuts in provider payment that otherwise would be necessary in the future as Medicare enrollment doubles over the next 30 years, since increased efficiencies alone will not be able to cover the increased costs.

The President's plan also includes administrative actions to assure a smooth implementation process, and we are continuing to explore other actions. Those already underway address several key areas of concern:

• *Inpatient hospital transfers.* The BBA requires the Secretary to reduce payments to hospitals when they transfer patients to another hospital or unit, skilled nursing facility or home health agency for care that is supposed to be included in acute care payment rates for ten diagnoses. It also authorizes HCFA to extend this "transfer policy" to additional diagnoses after October 1, 2000. To minimize the impact on hospitals, we are delaying extension of the transfer policy to additional diagnoses for two years.

• *Hospital outpatient payments.* The BBA requires Medicare to begin paying for hospital outpatient care under a prospective payment system (PPS), similar to what is used to pay for hospital inpatient care. This new system is schedule to go into effect in July 2000. To help all hospitals with the transition to outpatient prospective payment, we are considering delaying a "volume control mechanism" for the first few years of the new payment system. The law requires Medicare to develop such a mechanism because prospective payment includes incentives that can lead to unnecessary increases in the volume of covered services. The proposed prospective payment rule presented a variety of options for controlling volume and solicited comments on these options. Delaying their implementation would provide an adjustment period for providers as they become accustomed to the new system. We also are considering implementing a three-year transition to this new PPS by making budget-neutral adjustments to increase payments to hospitals that would otherwise receive large payment reductions such as low-volume rural and urban hospitals, teaching hospitals, and cancer hospitals. Without these budget-neutral adjustments, these hospitals could experience large reductions in payment under the outpatient prospective payment system. And, to help hospitals under the outpatient prospective payment system, we included a provision in the proposed rule to use the same wage index for calculating rates that is used to calculate inpatient prospective payment rates. This index would take into account the effect of hospital reclassifications and redesignations. For all of these outpatient department reform options, the rulemaking process precludes any definitive statement on administrative actions until after the implementing rule is published.

• *Rural hospital reclassification.* Hospital payments are based in part on average wages where the hospital is located. We are making it easier for rural hospitals whose payments now are based on lower, rural area average wages to be reclassified and receive payments based on higher average wages in nearby urban areas and

thus get higher reimbursement. Right now, facilities can get such reclassifications if the wages they pay their employees are at least 108 percent of average wages in their rural area, and at least 84 percent of average wages in a nearby urban area. We are changing those average wage threshold percentages so more hospitals can be reclassified.

• *Home health agencies.* The BBA significantly reformed payment and other rules for home health agencies. We are taking several new steps to help agencies adapt to these changes. We are increasing the time for repayment of overpayments related to the interim payment system from one year to three years, with one year interest free. Currently, home health agencies are provided one year of interest free extended repayment schedules. We are postponing the requirement for surety bonds until October 1, 2000, when we will implement the new home health prospective payment system. This will help ensure that overpayments related to the interim payment system will not be an obstacle to agencies obtaining surety bonds. We also are following the recommendation of the General Accounting Office (GAO) by requiring all agencies to obtain bonds of only $50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier. We also have eliminated the sequential billing rule that some agencies said was adversely affecting cash flow. And we are phasing-in our instructions implementing the requirement that home health agencies report their services in 15-minute increments.

Monitoring Access

We are proactively monitoring the impact of the BBA to ensure that beneficiary access to covered services is not compromised. We are systematically gathering data from several sources to look for objective information and evidence of the impact of BBA changes on access to quality care. These data sources include:

- beneficiary advocacy groups;
- health plans and providers;
- Area Agencies on Aging;
- State Health Insurance Assistance Programs;
- claims processing contractors;
- State health officials; and
- media reports.

We also are examining information from the Securities and Exchange Commission and Wall Street analysts on leading publicly traded health care corporations. This can help us understand trends and Medicare's role in net income, revenues and expenses, as well as provide indicators of liquidity and leverage, occupancy rates, states-of-operation, continuing lines of business as well as those exited or sold by the company, and other costs which may be related to discontinued operations.

We are examining Census Bureau data, which allow us to gauge the importance of Medicare in each health service industry, looking at financial trends in revenue sources by major service sectors, and tracking margin trends for tax-exempt providers.

We are monitoring the Bureau of Labor Statistics monthly employment statistics for employment trends in different parts of the health care industry. Such data show, for example, that the total number of hours worked by employees of independent home health agencies is at about the same level as in 1996. That provides a more useful indicator of actual home health care usage after the BBA than statistics on the number of agency closures and mergers. The data also show that nursing homes may be slightly reducing the number of employees and the hours that they work.

The HHS Inspector General's (IG) office has interviewed hospital discharge planners and nursing home administrators about the BBA's impact on patient care. The IG also has agreed to interview discharge planners about access to home health care following BBA payment reforms and the impact of the $1500 caps on outpatient therapy.

Specific BBA Provisions

Outpatient Rehabilitation Therapy. The BBA imposed $1500 caps on the amount of outpatient rehabilitation therapy services that can be reimbursed, except in hospital outpatient clinics. However, these caps are not based on severity of illness or care needs, and they appear to be insufficient to cover necessary care for many beneficiaries. We have several industry-sponsored analyses from different sources of 1996 claims data indicated that approximately 12 to 13 percent of therapy patients will exceed the caps. Beneficiary groups are reporting many instances of problems with this cap, and we are very concerned about their adverse impact, particularly on individuals in nursing homes. As mentioned above, our IG colleagues have

agreed to study this problem. We are providing data to the Medicare Payment Advisory Commission so it can analyze patterns of therapy service usage. And we will continue to work with Congress and others to determine what adjustments to the cap should be made.

Skilled Nursing Facilities. We implemented the new prospective payment system (PPS) called for in the BBA on July 1, 1998. The old payment system was based on actual costs, subject to certain limits, and included no incentives to provide care efficiently. The new system uses average prices adjusted for each patient's clinical condition and care needs, as well as geographic variation in wages. It creates incentives to provide care more efficiently by relating payments to patient need, and enables Medicare to be a more prudent purchaser of these services.

The BBA mandated a per diem PPS covering all routine, ancillary, and capital costs related to covered services provided to beneficiaries under Medicare Part A. The law requires use of 1995 costs as the base year, and implementation by July 1, 1998 with a three-year transition blending facility-specific costs and prospective rates. It did not allow for exceptions to the transition, carving out of any service, or creation of an outlier policy. We are carefully reviewing the possibility of making budget neutral administrative changes to the PPS.

We held a town hall meeting earlier this year to hear a broad range of skilled nursing facility concerns, and we continue to meet with provider and beneficiary representatives. There are concerns that the prospective payment system does not adequately reflect the costs of non-therapy ancillaries such as drugs for high acuity patients. The Inspector General found in its interviews of hospital discharge planners and nursing home administrators that less than 1 percent of nursing home administrators say the prospective payment system is causing access to care problems. The proportion of beneficiaries discharged to skilled nursing facilities is unchanged from 1998, and hospital lengths of stay have not increased. However, about one in five discharge planners say it takes more time to place Medicare patients in nursing homes. The IG also found that both nursing home administrators and hospital discharge planners say nursing facilities are requesting more information before accepting patients. About half of the nursing home administrators say they are less likely to accept patients requiring expensive supplies or services such as ventilators or expensive medications, about half also say they are more likely to admit patients who require special rehabilitation services such as physical therapy following joint replacement surgery.

We are therefore conducting research that will serve as the basis for refinements to the resource utilization groups that we expect to implement next year. We expect to have the research completed by the end of the year and to then develop refinements that we will be able to implement next October. Under the statute, we have the authority to refine these groups and redistribute money across categories in a budget neutral manner. We do not have discretion under the law to increase the overall level of payments to skilled nursing facilities. We fully expect that we will need to periodically evaluate the system to ensure that it appropriately reflects changes in both care practice and the Medicare population.

Home Health Agencies. The BBA closed loopholes that had invited fraud, waste and abuse. For example, it stopped the practice of billing for care delivered in low cost, rural areas from urban offices at high urban-area rates. It tightened eligibility rules so patients who only need blood drawn no longer qualify for the entire range of home health services. And it created an interim payment system to be used while we develop a prospective payment system. We expect to publish a proposed regulation this fall and to have the prospective payment system in place by the October 1, 2000 statutory deadline.

The interim payment system is a first step toward giving home health agencies incentives to provide care efficiently. Before the BBA, reimbursement was based on the costs they incurred in providing care, subject to a per visit limit, and this encouraged agencies to provide more visits and to increase costs up to the limits. The interim system includes a new, aggregate per beneficiary limit designed to provide incentives for efficiency that will be continued under the episode-based prospective payment system. Last year Congress increased the cost limits in an effort to help agencies during the transition to prospective payment. We are also taking the steps discussed above to help agencies adjust to these changes, and in March we held a town hall meeting to hear directly from home health providers about their concerns.

To date, evaluations by the GAO and HHS have not found that BBA changes are causing significant quality or access problems. Our monitoring of employment data shows that free standing home health agencies have made small reductions in their workforce, back to the level seen in 1996. However, we have heard reports from beneficiary groups, our regional offices, and others regarding home health agencies that have inappropriately denied or curtailed care, and incorrectly told beneficiaries that

they are not eligible for services. We are also hearing reports from beneficiary advocates and others that some high cost patients are having trouble finding home health agencies to provide the care they need. This may result from a misunderstanding of the new incentives to provide care efficiently, or from efforts to "cherry pick" low cost patients and game the system. The CBO attributes some of the lower health spending to the fact that agencies are incorrectly treating the new aggregate per beneficiary limit as though it applies to each individual patient.

We have therefore provided home health agencies with guidance on the new incentives and their obligation to serve all beneficiaries equitably. We have instructed our claims processing contractors to work with agencies to further help them understand how the limits work. And, because home health beneficiaries are among the most vulnerable, we are continuing ongoing detailed monitoring of beneficiary access and agency closures.

Hospitals. We have implemented the bulk of the inpatient hospital-related changes included in the BBA in updated regulations. We have implemented substantial refinements to hospital Graduate Medical Education payments and policy to encourage training of primary care physicians, promote training in ambulatory and managed care settings where beneficiaries are receiving more and more services, curtail increases in the number of residents, and slow the rate of increase in spending. We have implemented provisions designed to strengthen rural health care systems. We have carved out graduate medical education payments from payments to managed care plans and instead are paying them directly to teaching hospitals (and are proposing in the President's Medicare reform plan to similarly carve out disproportionate share hospital payments).

We expect to implement the prospective payment system for outpatient care next year. The outpatient prospective payment system will include a gradual correction to the old payment system in which beneficiaries were paying their 20 percent copayment based on hospital charges, rather than on Medicare payment rates. Regrettably, implementation of the prospective payment system as originally scheduled would have required numerous complex systems changes that would have substantially jeopardized our Year 2000 efforts. We are working to implement this system as quickly as the Year 2000 challenge allows. We issued a Notice of Proposed Rule Making in September 1998 outlining plans for the new system so that hospitals and others can begin providing comments and suggestions. We are actively reviewing all of the comments from the industry and other interested parties that we received during the comment period, which we extended until July 30. We are focusing most of our continuing work on rural, inner city, cancer, and teaching hospitals because our analysis suggests that the outpatient prospective payment system will have a disproportionate impact on these facilities. And we are continuing to develop modifications to the system for inclusion in the final rule.

The hospital industry has submitted data projecting significant decreases in total Medicare margins. Our actuaries believe the methodology used to develop these projections understates base year total margins by approximately 7 percent. And, according to the Medicare Payment Advisory Commission (MedPAC), Medicare costs per case have declined for an unprecedented fifth year in a row. However, MedPAC also notes that while rural hospitals have generally posted healthy margins, many small rural hospitals appear to be in especially poor financial condition.

We continue to hear reports of financial distress, and we understand the challenge hospitals are facing in today's changing health care marketplace. We are reviewing the data as it comes in, and we will continue to monitor this situation closely.

Physicians. As directed by the BBA, we are on track in implementing the resource-based system for practice expenses under the physician fee schedule, with a transition to full implementation by 2002 in a budget-neutral fashion that will raise payment for some physicians and lower it for others. The methodology we used addresses many concerns raised by physicians and meets the BBA requirements. We fully expect to update and refine the practice expense relative value units in our annual regulations revising the Medicare fee schedule. We included the BBA-mandated resource-based system for malpractice relative value units in this year's proposed rule. We welcome and encourage the ongoing contributions of the medical community to this process, and we will continue to monitor beneficiary access to care and utilization of services as the new system is fully implemented.

The President's fiscal 2000 budget contains a legislative proposal for a budget-neutral technical fix to ensure the BBA's sustainable growth rate (SGR) for physician payment is stable. Medicare payments for physician services are annually updated for inflation and adjusted by comparing actual physician spending to a national target for physician spending. The BBA replaced the former physician spending target rate of growth, the Medicare Volume Performance Standard, with the SGR. The SGR takes into account price changes, fee-for-service enrollment changes,

real gross domestic product per capita, and changes in law or regulation affecting the baseline. After BBA was enacted, HCFA actuaries discovered that the SGR system would result in unreasonable year-to-year fluctuations. Also, the SGR target cannot be revised to account for new data. The President's budget proposal addresses both of these concerns.

Medicare+Choice. Successfully implementing this program is a high priority for us. Medicare managed care enrollment has tripled under the Clinton Administration, and there are now 6.48 million beneficiaries enrolled in Medicare+Choice plans. We meet regularly with beneficiary advocates, industry representatives, and others to discuss ways to improve the program. We launched a national education campaign and participated in more than 1,000 events around the country to help beneficiaries understand it. And we are establishing a federal advisory committee to help us better inform beneficiaries.

We have taken steps to assist plans and encourage plan participation in Medicare+Choice. We worked with Congress to give plans two more months to file the information used to approve benefit and premium structures so plans were able to use more current experience when designing benefit packages and setting cost sharing levels. We also published refinements to Medicare+Choice regulation that improve beneficiary protections and access to information while making it easier for health plans to offer more options. The new rule:

- clarifies that beneficiaries in a plan that leaves the program are entitled to enroll in remaining locally available plans;
- specifies that changes in plan rules must be made by October 15 so beneficiaries have information they need to make an informed choice during the November open enrollment;
- allows plans to choose how to conduct the initial health assessment;
- waives the mandatory health assessment within 90 days of enrollment for commercial enrollees who choose the same insurer's Medicare+Choice plan when they turn 65, and for enrollees who keep the same primary care provider when switching plans;
- stipulates that the coordination of care function can be performed by a range of qualified health care professionals, and is not limited to primary care providers;
- limits the applicability of provider participation requirements to physicians; and,
- allows plans to terminate specialists with the same process for terminating other providers.

We intend to publish a comprehensive final rule with further refinements this fall.

We have also undertaken a comprehensive beneficiary education program. We launched the National Medicare Education Program to make sure beneficiaries receive accurate, unbiased information about their benefits, rights, and options. The campaign includes:

- mailing a Medicare & You handbook to explain health plan options;
- a toll-free "1–800-MEDICARE" [1–800–633–4227] call center with live operators to answer questions, and provide detailed plan-level information;
- a consumer-friendly Internet site, www.medicare.gov, which includes comparisons of benefits, costs, quality, and satisfaction ratings for plans available in each zip code;
- working with more than 120 national aging, consumer, provider, employer, union, and other organizations who help disseminate information to their constituencies;
- beneficiary counseling from State Health Insurance Assistance Programs;
- a national publicity campaign;
- a Regional Education About Choices in Healthcare (REACH) campaign that will conduct State and local outreach activities nationwide; and,
- a comprehensive assessment of these efforts.

We tested the system in five States in 1998 and learned how to improve efforts for this November's open enrollment period. For example, we have made the Medicare & You handbook easier to use and improve the accuracy of information about plans that are withdrawing. We have added new links on our Medicare Compare website at www.medicare.gov to help users find information faster. We are standardizing plan marketing materials that summarize benefits so beneficiaries can more easily make apples-to-apples comparisons among plans in this November's open enrollment period. And we have added information on managed care plan withdrawals to the Important Notes section of the 1999 plan information on our Medicare Compare website.

To help us continually improve our education efforts, we are establishing the Citizens' Advisory Panel on Medicare Education, under the Federal Advisory Committee

Act. The panel will help enhance our effectiveness in informing beneficiaries through use of public-private partnerships, expand outreach to vulnerable and underserved communities, and assemble an information base of "best practices" for helping beneficiaries evaluate plan options and strengthening community assistance infrastructure. Panel members will include representatives from the general public, older Americans, specific disease and disability groups, minority communities, health communicators, researchers, plans, providers, and other groups.

The BBA also initiated important payment reforms that begin to correct for historical overpayment. It established a competitive pricing demonstration in which plan payment rates will be set through a bidding process, similar to what most employers and unions use to decide how much to pay plans. And, starting in January, the BBA mandates that we "risk adjust" payments to account for the health status of each enrollee. Studies by the Congressional Budget Office, Physician Payment Review Commission, and many others have shown that we overpay plans in part because Medicare fails to adjust payments for the health of enrollees.

That is why risk adjustment cannot be budget neutral. The vast majority of beneficiaries enrolled in Medicare+Choice cost far less than what Medicare pays plans for each enrollee. Budget neutral risk adjustment would mean Medicare and the taxpayers who fund it would continue to lose billions of dollars each year on Medicare+Choice. Budget neutral risk adjustment would cost taxpayers an estimated $11.2 billion over the five years that we are phasing it in if health plans maintain their current, mostly healthy beneficiary mix.

We are concerned about disruptions to beneficiaries caused by plan decisions to trim participation in Medicare+Choice. The GAO reported in April that many factors contribute to such decisions. For instance, plans may have trouble establishing adequate provider networks, enrolling enough beneficiaries to support fixed costs, or otherwise competing in a given market.

However, inadequate reimbursement to plans does not fully explain these plan decisions. Payment is rising in all counties this coming year by an average of 5 percent. In fact, despite BBA reforms, aggregate payment to plans continues to be excessive, according to another GAO report released in June, because of a forecasting error that the BBA locked into the statutory payment formula. The result is that plans are being paid an additional excess amount that totaled $1.3 billion in 1998 and will increase each year.

BBA reforms may, however, mean that payments in some counties no longer include enough excess to cover losses in other areas or to subsidize extra benefits that fee-for-service Medicare does not currently cover, such as prescription drugs.

Clearly all beneficiaries need a more stable and reliable source of prescription drug coverage. And, if plans' primary problem is paying for benefits beyond the Medicare benefit package, the best solution is to improve the benefit package by providing all beneficiaries with access to an affordable prescription drug benefit, and paying plans explicitly for providing it.

The President's Medicare reform plan gives all beneficiaries the option to pay a modest premium for a prescription drug benefit that will cover half of all prescription drug costs up to $5,000 when fully phased in, with no deductible. Medicare+Choice plans would be explicitly paid for providing a drug benefit, and would no longer have to depend on what the rate is in a given area to determine whether they can afford to do so.

The President's plan also will modernize the way Medicare pays managed care plans. Rates would be set through competition among plans rather than through a complicated statutory formula. All plans would be paid their full price through a combination of government and beneficiary payments. The lower the price, the less beneficiaries pay. And the President's plan also includes several provisions to preserve beneficiary options and strengthen protections when plans withdraw from Medicare.

Conclusion

The BBA made important changes to the Medicare program to strengthen and protect it for the future. These changes, along with a strong economy and our increased efforts to combat fraud, waste, and abuse, have extended the life of the Trust Fund until 2015. With changes of the magnitude encompassed in the BBA, some issues have arisen that may require adjustment and fine tuning. The President's Medicare reform plan sets aside $7.5 billion to smooth out implementation of BBA reforms. The President's plan also includes administrative adjustments to help in the transition to new payment systems. It dedicates a portion of the budget surplus to Medicare, which will help protect against excessive provider payment re-

ductions in the future as Medicare enrollment doubles over the next 30 years, and increased efficiencies alone will not be able to cover the increased costs.

It is not surprising that necessary market corrections would result from such significant legislation. As always, we remain concerned about the effect of policy changes on beneficiaries' access to affordable, quality health care. We are proactively monitoring the impact of the BBA to ensure that beneficiary access to covered services is not compromised. We welcome the opportunity to look at any new information regarding beneficiary access to quality care. We are committed to continuing to look at refinements to the BBA that are within our administrative authority.

We also are committed to working with Congress to enact bipartisan Medicare reform this year that makes a prescription drug benefit available and affordable for all beneficiaries, dedicates a significant portion of the budget surplus to Medicare, and sets aside funding specifically for smoothing out BBA payment reforms.

I thank you for holding this hearing, and I am happy to answer your questions.

Chairman THOMAS. In reading the testimony there are some concerns, and I know that you could not be as explicit as you might want to be, but you have clearly pointed out some areas that we need to address. There is no question that, for example, on page 7 of your testimony, we need to deal with the therapy caps, whether we decouple the speech and physical and the dollar amounts themselves or whether we talk about focusing on extremely high-cost activities, although relatively few, that would be very damaging to any structure of the total cost.

We believe that that would require legislative action, and are ready and willing, I think you will find this committee, to address that.

Additionally on page 8, although you did move forward with the prospective payment system for skilled nursing facilities, the so-called resource utilization groups, they are clearly not sophisticated enough to deal with acuity questions, and those are some of the data that Congress is interested in. And although you suggest you can make some adjustments on a budget-neutral basis, I believe we are going to have to sit down and talk about providing some additional dollars. Given your Y2K problems you are not going to be able refigure the RUGs, I understand, but we could at least use some surrogates for acuity in replacing some appropriate additional amounts in appropriate categories. I think you will find this committee will be willing to work with you in that area.

One of the questions that is constantly asked: How much money are we talking about? Everybody wants to know the bottom line before you get there. I do have some concern about your statement in terms of the President's willingness to commit to $7½ billion over 10 years to making some of these adjustments. I believe on page 3, you indicate that the President has set aside those kinds of funds. Is it not accurate that in the President's budget, had he had his way beyond the adjustments in the Balanced Budget Act, over a 5-year period there would have been more than $12 billion in additional Medicare reductions, more than $28 billion over 10 years? Is that accurate or approximately accurate? Did the President's budget plan additional reductions in the Medicare area?

Mr. HASH. The President's budget for 2000 did include proposed reductions in Medicare outlays; that is correct, Mr. Chairman. I do believe that in the context of the reform plan that he announced

this summer, the assumption is that the proposals in the reform plan relating to Medicare are the ones which are in place and the ones we are trying to talk about together today.

Chairman THOMAS. I understand. But that leads me to another concern on that same page 3; for example, the final sentence in the third paragraph that said in terms of the adjustments that you have offered on the President's reform plan this will help prevent, "excessive cuts in provider payments that otherwise would be necessary in the future as Medicare enrollment doubles over the next 30 years."

To some people, that says volumes about where you are suggesting reforms would be coming from, just as the $28 billion over 10-year additional reductions in the President's plan indicated, that the adjustments probably should come from additional ratcheting down of providers. You show no indication in this sentence or paragraph, or to my ability to find it anywhere else, a discussion of whether or not millionaires are going to continue to receive benefits across the board or other suggested changes that the Medicare commission spent more than a year examining and offered up as suggested proposals. My assumption is that you—this was simply one of those lines that you placed in there and that you are not opposing, looking at additional changes other than cuts in provider payments.

Mr. HASH. No, Mr. Chairman, we are not opposed to looking at other things. And in fact in the President's proposal, there are details that involve not only changes in Medicare payment policies but importantly, as we all know, if we are going to extend the life of the Medicare program beyond 2015, given the increase in the number of beneficiaries, it is going to take additional revenues. And a significant portion of the President's proposal is the dedication of 15 percent of the on-budget surplus over the next 10 years to extend the life of the program and to mitigate the need for additional provider and beneficiary cost-sharing changes.

Chairman THOMAS. Did the President's plan include an income-relating provision?

Mr. HASH. No, Mr. Chairman, it does not. It does include changes in the Part B deductible and in cost sharing for beneficiaries.

Chairman THOMAS. Thank you. On page 10, again as I indicated in my opening statement, that there have been some difficulties because of the Y2K computer adjustment. You have not been able to meet some of the deadlines that we thought were appropriate. One of the areas that I am most concerned about is in adjustments for the outpatient prospective payment system, because for some time now, beneficiaries have because of the way in which the payment structure is determined, have been paying more than their fair share, is the way I think you could state it. Now, when we had the administrator—and I understand she is still on maternity leave and things are going well with Nicholas and we are all very pleased for her.

Mr. HASH. Yes, sir.

Chairman THOMAS. The delay from January to April, a 3-month delay, was going to cost about $570 million. Is that roughly the correct amount?

Mr. HASH. I believe that is the figure that has been put forth by the CBO.

Chairman THOMAS. Do you have a quarrel with that figure?

Mr. HASH. I do not, Mr. Chairman.

Chairman THOMAS. So that is additional overcharge to the beneficiaries. If we are going to extend that now from April, if you are not going to be able to make that time line, when do you think you are now going to be able to have it still up and running?

Mr. HASH. Mr. Chairman, our intention is as soon as we pass the Y2K window at the end of March, we will bring up the hospital prospective payment system as soon as possible, after giving providers sufficient notice and contractors sufficient notice to prepare for it, and I think that would be by the middle of the summer.

Chairman THOMAS. Middle of summer. July sound good?

Mr. HASH. Yes, sir.

Chairman THOMAS. From January to April was 3 months; from April to July is 3 months. That is 6 months. And if, in fact, the first 3 months was 570 million and the second 3 months is somewhere in that same ballpark, there is $1 billion. And I counted more than a dozen specific areas that we need to look at and make adjustments in the Balanced Budget Act, and in this one minor area under the general category of hospitals—and I have 3 or 4 additional suggestions for hospitals—that 6-month delay is costing $1 billion. And yet the President has decided that he is going to set aside $7–½ billion for 10 years. Obviously the point I am underscoring is when we make mistakes, when we miss deadlines and when we have to make adjustments, dollar amounts, although they may seem significant, looking at them in making a balanced structure for beneficiaries, here is $1 billion that they are going to be overcharged in just a 6-month period, which I have some concern about and need to talk to some folks about how we make sure that they don't continue to carry more than their fair share.

Mr. HASH. If I may, Mr. Chairman, comment on that. We share your concern about the impact of this delay on the beneficiaries' out-of-pocket expenses. And one of the aspects of this, which we have tried to address in the implementation plan, is when the cost sharing begins in July 1 of next year, it will begin at a point that it would have been had the payment system been put into place on January 1, 1999.

Chairman THOMAS. And I would just tell you, Michael, that that is the kind of cooperation and thinking we need, because some of these adjustments that are overdue need to be done in a budget-neutral way, so that time lines can pick up from the time that we begin. Where you think you can do it, I would like to know. Where you are unwilling to do it, we absolutely need to know. And where you are willing to do it but don't believe you have the ability, I believe you will find Congress more than willing to clarify when you are going to stretch out, make adjustments, and appropriately soften deadlines. I appreciate working with you.

Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman. Just two issues Mike, on the outpatient prospective payment. It is my understanding that you do not have the authority to offset those payment reductions. There are some advertisements being run hither and yon that it

was the legislative intent that those payments did not cause reductions to the hospitals. Now, CBO did not score that as a cost of Medicare as they would of had to do. They didn't accidentally overlook the $2 billion of cost. I just wanted to set the record straight that the law was not intended to offset the costs to hospitals of the reduction in the outpatient prospective payment; is that correct?

Mr. HASH. I believe you are correct, Mr. Stark. Bringing into line the co-insurance amounts by beneficiaries to equal 20 percent of the outpatient charge is a cost that is being borne by the hospitals in the form of payments that would otherwise have been made.

Mr. STARK. Just to set the record straight, our intention was to save the beneficiaries that excessive out-of-pocket cost. We did not intend to charge it to the taxpayers, but indeed to see that it came out—as easy as we could make it—out of the hospitals.

The other issue that you raise in your testimony deals with reimbursement for managed care. You suggest that inadequate reimbursement to those plans does not explain the decisions for plans to stop providing service. I think that you indicate that in many areas the plans just couldn't find a big enough patient base to make them viable at any cost. In other words, you need a certain minimum number of people to sign up to be able to keep surgeons and other providers on call. Second, you also suggest that we are for the most part overpaying the managed care plans, absent any risk adjustment. Is that a fair assessment of your testimony?

Mr. HASH. I believe it is, Mr. Stark, and it I believe has been the testimony of others, GAO and the Congressional Budget Office and the Prospective Payment Assessment Commission, the predecessor to MedPAC.

Mr. STARK. Now, I have often suggested the following to hospitals and laid down a challenge to them, but to my knowledge I haven't heard back from one hospital. Medicare is no longer the lowest payer for any particular DRG that a particular hospital is receiving. Aetna or Pacific Care or other of the managed care plans have negotiated contracts with those hospitals and indeed are paying far less than the Medicare system pays them. There is no question that the hospitals were good sports in previous years and costshifted onto these private insurance companies when Medicare was a lower payer.

But what is your assessment—and I know we don't have a database, so absent the hospital saying anything, and you can figure if they had the figures they would show them to us? My sense is they are silent because they know very well that what they are attempting to do is get the taxpayers to raise the payments to the hospitals in order to make up for poor management decisions in underpricing the services to managed care plans. I can't find any reason why I should go back to my taxpayers and say you guys should bail out these hospitals. They should go back and raise the prices to the managed care plans and then come back. Can you comment on that and do you have any statistics that would support my theory or prove or disprove it?

Mr. HASH. What we have seen in looking at the data over the last 5 years is that hospitals have been under significant pressure to discount for purposes of contracts with organized delivery systems. And that is pretty well established in the literature. I think

what has happened is that as the rate of growth in Medicare payments, particularly as a result of the BBA, has slowed compared to what it was in the past, that has put increased pressure on hospitals because of their inability to subsidize those losses on the private side with Medicare payments.

Mr. STARK. But just if I could repeat, would it be your opinion that on average, or for the most part, that Medicare is paying a higher DRG rate than managed care plans?

Mr. HASH. You know, as you said, Mr. Stark, I don't have an empirical basis to make that statement. I am sure it varies across the country, but I do believe that in some areas the DRG payments under Medicare would be higher than comparable private sector payers.

Mr. STARK. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. The gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON of Connecticut. Thank you very much. It is a pleasure to have you here at this hearing. I consider this one of the most important hearings we have had in the whole year in this session.

There are many, many areas that need to have our attention as well as yours. Let me just go to one in the area of nursing homes. You do say in your testimony that the Inspector General found in its interviews of possible discharge planners or nursing home administrators, that less than 1 percent of nursing home administrators say the prospective payment system is causing access problems. You do go on then to other data that suggests the problem is much more serious than that.

I would suggest to you that in testimony today that we are going to hear that the problem is really much more serious than that: that 58 percent of discharge planners identified patients who required excessive services have become more difficult to place in SNF since Medicare cuts. This is a very serious problem. The only reason beneficiaries aren't feeling it more keenly in my estimation is that nursing homes are compelled by law, at least in Connecticut, to participate in both Medicare and Medicaid. Most of them in Connecticut at least are nonprofits and they care a lot about their patients and they are not about to not take them even though they lose money on them. So I don't think whether they are getting placed should be our concern. Whether they are having a harder time to get placed, whether the nursing homes are asking for more information, which they clearly are, should very much be our concern. And I know it is the Chairman's and I know it is yours. I hope that we can accelerate your timetable a good deal, because I think a year from now is much too late to be able to implement something that will do something about this.

But as important as the RUGs are, you have by administrative action excluded a number of things that you considered not common nursing home responsibilities from the RUGs. And I would ask you, I have been asking for months for you to look at exclusion of prosthetic devices, because if you bill prosthetic devices into RUGs and you reimburse every nursing home across the country a little tiny bit, and they never have anyone who needs a $7,000 prosthetic device, then the small nursing home, especially a very

little one, can't absorb that $7,000 cost on a reimbursement rate of $200.

So are you looking at excluding prosthetic devices and are you looking at excluding ambulance services for dialysis? In my district, rural hospitals, those ambulance costs are $800 a time. If you get someone who needs then dialysis, you simply can't do this. We can't impose on these institutions automatic losses for things that are clearly a public responsibility to pay for. So on exclusion of those issues which I think we need to do in addition to adjusting the RUGs, where is the administration?

Mr. HASH. Mrs. Johnson, we too are concerned not only about admission and access to nursing facilities, but also that patients who are residents in nursing facilities are getting the care that they need. That is why, as you noted, we have identified a number of services that we think don't fall within the responsibilities of the nursing home to provide to their patients. In other words, it is not in the plan of care—for example, they have a heart attack or they have some need for a hospital-based service that was clearly not anticipated and for which the nursing home is not able to provide. Those are the kinds of things that we carved out.

When it comes to issues that are actually part of the nursing home plan of care, I think our reading is that the statute is very clear about not unbundling things from the PPS rate in SNFs that are normally associated with care provided in that organization. But it doesn't mean that we aren't looking, as you know, at those RUGs that involve care for patients with high——.

Mrs. JOHNSON of Connecticut. So am I to conclude from your answer that you are not considering any further exclusions?

Mr. HASH. I think there are various ways to deal with the specific problem that you brought up.

Mrs. JOHNSON of Connecticut. I have had no response to my letter from Dr. Berenson. I mean through the staff we have, but no final response. I need to know before this markup. Are you willing to deal with—we deal with transportation for dialysis in certain situations and not in others. This definitely has to affect a nursing home's consideration because they have a fiduciary responsibility to stay alive to serve the rest of their patients.

So prosthetic devices, transportation for dialysis, transportation for radiation therapy, and clearing up who pays for chemotherapy are just fringe issues that we have got to deal with before we get to this markup, because it is imperative that we remove the threat of high—of some of the definable high cost. Medication is more difficult. But at least some of these are clear, succinct. We got to act.

Mr. HASH. We definitely want to work with you in the context of the legislation, and I will get a response to you prior to your markup, and I apologize.

Mrs. JOHNSON of Connecticut. Would you also update me at the same time as to where the administration's thinking is on a small provider exception? Because the little small nursing homes with 60 beds and 2 Medicare patients cannot carry the administrative burden. They only have bookkeepers, they don't have Arthur Andersen people.

Mr. HASH. I want to make a point about the dialysis example, because we too are concerned about that, and what we are trying

to do is to work with nursing homes and State licensing authorities to make sure that nursing homes can provide the dialysis service on the premises, making an ambulance trip unnecessary.

Mrs. JOHNSON of Connecticut. We will discuss that. Thank you.

Chairman THOMAS. The gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Hash, if, in fact, HCFA would go forward and administratively make some of the changes necessary to provide some refinements, how would that be treated for budget purposes?

Mr. HASH. I don't believe for your purposes here in the Congress that those are considered, that Congress is scored for those, and those are considered to be program expenditures under the existing law and therefore not counted as new spending.

Mr. KLECZKA. Will it come out of trust fund?

Mr. HASH. Yes.

Mr. KLECZKA. So it would be like emergency spending in Congress. If we term it emergency spending, be it the census or whatever, then it is a free pass for us. So it is incumbent upon us in Congress to try to have you do it, but the fiscal effect is still there.

Mr. HASH. The fiscal effect is still there but the rationale, if you will, Mr. Kleczka, is this is what was intended in the law and therefore it obligates those expenditures appropriately from the trust funds.

Mr. KLECZKA. But a readjustment of the trust fund would have to happen at some point. We have all heard from various interests who have been adversely affected by the Balanced Budget Act of 1997.

Let me just broach two areas real quickly. The family medicine training programs have been affected adversely by the changes. There is a fear there that some of these programs will be forced to close and there will be a shortage of family physicians. I am assuming that HCFA has tracked this and other areas. What is your reaction to that contention?

Mr. HASH. We definitely recognize that the BBA provisions for graduate medical education limit, by capping, the number of new residencies, and they do not allow for any growth unless institutions actually reduce training programs, say, in speciality areas in order to allow for increases in things like family medicine. The statute is very explicit in this area. But we would certainly be willing to work with you with respect to legislative considerations on that issue.

Mr. KLECZKA. Do you have any fear if we do not address this area we could be facing shortages in this area in the future?

Mr. HASH. I am not aware of any data yet. That is not to say it may not turn out that we are facing a shortage in that regard. But again, I think we should look into this and work with you to identify if some modification of those limits on residents in training should be made.

Mr. KLECZKA. Also, yesterday I had the occasion to meet with some cardiologists from my district. And they have voiced concern about the way the practice expense components were developed and they said that if you continue the phase-in, the problems will only be exacerbated. Is there any interest on the part of HCFA ei-

ther to delay the phase-in or to provide some adjustments in that area?

Mr. HASH. At the moment, we are continuing our phase-in which concludes in 2004, I believe. What we have done, though, to address the issue of practice expense was to work with the American Medical Association and use their practice expense data that they collect on an annual basis as the basis for establishing relative practice value weights. We think that more accurately includes the cost of practice as reported by physicians themselves.

Mr. KLECZKA. We have all heard much concern about the therapy caps. I think you have addressed this earlier in your testimony but could you restate the HCFA position on the therapy caps?

Mr. HASH. Our view is there is significant evidence that some patients are not getting access to an adequate amount of therapies and we would like to work with the Congress to make some adjustments to those limits.

Mr. KLECZKA. Now that particular adjustment, would that have to be legislative or could that be administrative?

Mr. HASH. That would have to be legislative, I believe.

Chairman THOMAS. Would the gentleman yield on that point briefly? I think we do have to put it in the context of the fact that therapy capabilities from a hospital-based structure are not limited.

Mr. HASH. That is correct.

Chairman THOMAS. And that given your inability to keep the records as appropriately as they should be, someone can receive therapy even to a $1,500 cap in different locations and you are not now able to determine that. Is that correct?

Mr. HASH. That is correct, Mr. Chairman.

Chairman THOMAS. So we want to put the concern in its proper context that it is causing some concerns, but that what we want to look for is evidence that people are being denied cold, hard therapy where they absolutely need it, and that in fact there needs to be some corrections to the structure as well. But I want to underscore I agree there needs to be an examination of this area, but let's not leave the belief that it is $1,500 for everyone in every instance, with no opportunity to do anything else.

Mr. KLECZKA. Let me ask the Chair a quick question. Is it your contention that once the cap is attained in one particular treatment area, that patient can then be moved to another to start the 1,500 over again?

Chairman THOMAS. No I am just telling you that is reality, because HCFA cannot monitor that kind of activity. I don't think that should be the basis for receiving more than the cap amount. I think we need to look at an appropriate amount. This area was increasing at 18 percent a year when we did not see an increased need at that percentage. What we can do is create an outlier payment structure for the needed prosthetic, let's say, or for brain damage which clearly over a period of time takes enormous investment, far beyond that amount for therapy, but over the life of that individual a significant return to society, if we are in fact able to rehabilitate them, beyond the condition that they are in, there is good reason to make some adjustments.

But I just didn't want to leave the impression that it is a hard and fast $1,500 cap for every person in America and that is what we are dealing with. That is not the case, but we are going to make some adjustments.

Mr. KLECZKA. Well, when we take the Chairman's mark to a markup, I am assuming we will have a lot more discussion on this particular area.

Thank you, Mr. Hash.

Chairman THOMAS. The Chairman took some of your time. You want to spend a few minutes?

Mr. KLECZKA. Well, maybe we will come back.

Chairman THOMAS. Does the gentleman from Texas wish to inquire?

Mr. JOHNSON of Texas. Yes. Thank you. I agree with you, Mr. Kleczka; that point is something I want to bring up too. I would like to know why you guys keep leaning on Y2K and saying that it is the reason you can't do something. Is that the reason or is it because you just haven't gotten your act together?

Mr. HASH. Well, Mr. Johnson, it is the reason. We have had a very significant challenge in making sure that all of our computer systems that process Medicare claims and our other information systems were in fact Y2K compliant. We felt that that was our No. 1 priority.

Mr. JOHNSON of Texas. Are they now?

Mr. HASH. We believe they are now. As you know, what we are concerned about today is the provider and health plan community, and making sure that they have taken the steps to be ready.

Mr. JOHNSON of Texas. That is true. But why can't you work on implementing the Balanced Budget Act now?

Mr. HASH. Because our internal and external advisors on Y2K compliance advised us that during the period October 1 through March 31, 2000 that we should not make any systems changes because those could, in some unintended way, affect our Y2K readiness. So we are not making any changes in our systems through our contractors until we pass through the Millennium.

Mr. JOHNSON of Texas. It seems to me if the Federal Reserve and banks and other organizations can do it now, make changes, that you ought to be able to as well. And I don't understand after Y2K occurs, which is the first of the year, and you have no problems, presumably, why you can't get on with it. Why do you have to wait until March?

Mr. HASH. If we do not have any problems that require remediation, we expect to accelerate our return to regular changes in our claims processing systems.

Mr. JOHNSON of Texas. I wish you guys would get with it.

Let me ask another question. As you continue to do your risk adjustor phase-in, are you worried about the possibility of Medicare+Choice plans continuing to pull out of the markets, presuming they are?

Mr. HASH. Mr. Johnson, as I think Mr. Stark alluded to in his statements a moment ago, we believe that the decisions about plans staying or leaving the program are related to a variety of factors in the marketplace, and, in fact, the coming in and leaving

Medicare+Choice is still going on and I think it is reflective of larger changes in the health insurance marketplace.

We don't think that the risk adjustment is a significant factor in the decision whether or not a plan will contract or continue to contract with the Medicare program.

Mr. JOHNSON of Texas. OK. Let me ask you, in 1989, Congress codified that the 10 freestanding designated cancer centers were to be exempt from inpatient PPS. Now, why are these 10 hospitals not exempt from outpatient PPS as well and given some kind of relief?

Mr. HASH. We have met with them and are considering very carefully a large number of concerns from cancer centers about our proposed outpatient PPS system. As a result, we expect when we publish our final rule to make a number of changes, taking into account what the Congress said in the BBA, which gave us discretion with respect to a number of items in the hospital PPS payment system as it affects cancer hospitals.

We intend to exercise the discretion in the law, and we intend to address the concerns that have been raised by the cancer centers when we publish our final rule.

Mr. JOHNSON of Texas. You more or less answered it, but why did you decide not to exempt the outpatient PPS?

Mr. HASH. We don't believe that the Balanced Budget Act actually provides for an exemption. It provides for special consideration of cancer hospitals. That is what we intend to do.

Mr. JOHNSON of Texas. The bulk of their business, as you know, is Medicare-Medicaid.

Mr. HASH. Yes, sir.

Mr. JOHNSON of Texas. I think we need to take care of them.

I would just like to make one more statement, if I could.

I would say to Mr. Stark, I think he slammed the hospital systems a little bit. I would like to say that I have been dealing with them for a long time, and I don't think that they are fraudulent or attempting to harm the patient population in any way. They are hurting for dollars. I think that we need to get out there and figure out where the costs really are and make adjustments.

Mr. STARK. If the gentleman from Texas would yield, I agree. I just wanted to suggest that the tables have turned in recent years, and the fees that we pay the hospitals with the taxpayers' money are higher than they are getting from many of the private insurance plans. Perhaps we ought to see the private insurance plans pay a little more before we use the taxpayers' money.

That may or may not be the hospital's fault. I am just suggesting we don't have that data, and I think we could be more fair if we had it.

Mr. JOHNSON of Texas. Thank you for the clarification.

Chairman THOMAS. I would tell the gentleman from Texas, my recollection is that the Balanced Budget Act indicated there could be a 1-year delay in implementing the outpatient PPS, clearly to examine whether or not it is appropriate and what changes might need to be made; not that the exemption would not be an ultimate decision that may be made, but it would be premature. We should look at it.

I hope that, notwithstanding the delay on the outpatient PPS, that the administration intends to carry forward whatever delays

were attached to the original date in a systematic and uniform way.

Can you make a quick comment on that?

Mr. HASH. Mr. Chairman, as you know, we are in the process of putting together the final rule on this.

Chairman THOMAS. That was not my question. If you don't want to answer it, just say you can't answer it at this time.

Mr. HASH. I can't answer it at this time definitively.

Chairman THOMAS. Then we will deal with it. But you should not require everyone to meet a timetable when the BBA said there was a 1-year delay, and just because you failed to meet the timetable, other people have to suffer for it. That is not the way, in a mutual spirit of cooperation, we ought to carry out that.

Mr. HASH. I understand, Mr. Chairman.

Chairman THOMAS. If you need some legislative statement to that effect, which I hope you don't, because it will open up the other question, that is what we are going to have to talk about.

Does the gentleman from Georgia wish to inquire?

Mr. LEWIS. Thank you very much, Mr. Chairman.

Thank you, Mr. Hash, for being here.

Chairman THOMAS. If the gentleman will yield just briefly, it is the chairman's intention not to recess for this vote. So those of you who have already had your opportunity, if you would go on over, we are going to try to keep this rolling so we don't unnecessarily delay individuals.

I thank the gentleman.

Mr. LEWIS. Thank you, Mr. Chairman. I will be very brief.

Thank you, Mr. Hash, for being here.

Mr. Hash, this subcommittee is likely to hold a markup of legislation to fix some of the impact of the BBA. If we don't find an offset to pay for such fixes, will we be spending from the Social Security surplus? Could you tell me about that?

Mr. HASH. Mr. Lewis, I don't have all the details on the available on-budget surplus for this and future years, so it would depend on whether that money has already been exhausted. And if it has been because it is committed to other uses, then anything spent beyond that would come from the off-budget surplus, which would be the Social Security surpluses.

Mr. LEWIS. Could you please describe for me and other Members of the Committee the effect that the House HHS appropriation bill will have on your agency?

Mr. HASH. Yes, sir, Mr. Lewis, I would. I think it would be devastating for us.

Mr. LEWIS. Could you go into detail and just describe to Members of the Committee how devastating would the appropriation impact be?

Mr. HASH. It would affect us across all of our business and programmatic activities, including very substantial reductions, in fact, the virtual elimination of our education campaign for Medicare beneficiaries. It would definitely cripple our initiative with respect to insuring the quality of care in nursing homes and our oversight of nursing homes. It would significantly impact our ability to continue making changes in payment systems and the workload that is associated with that.

We have, as you know, Mr. Lewis, one of the very smallest budgets in relation to the programmatic dollars that we are responsible for. Less than 2 percent of our administrative budget, less than 2 percent of Medicare's expenditures are consumed by our administrative budget. So cuts of the magnitude proposed by that Subcommittee mark would definitely be devastating for our agency.

Mr. LEWIS. What would be the effect on fraud and abuse enforcement?

Mr. HASH. That is another area where the proposed mark reduces substantially the funds that Congress set aside in a special, dedicated fund for this purpose and reduces them, as I understand, by $70 million. That would be a very substantial reduction in our effort to continue our aggressive oversight of waste, fraud, and abuse in our programs, which has been so important in returning multiple dollars for every Federal dollar invested in this effort, to return those dollars several-fold to the trust funds.

Mr. LEWIS. Thank you very much, Mr. Hash.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Does the gentleman from Michigan wish to inquire?

Mr. CAMP. Yes, thank you, Mr. Chairman.

My question is regarding the critical access hospital program. The Balanced Budget Act created this new designation for certain rural hospitals to be designated as critical access hospitals. Many have said this program is an attractive program because it would allow them to serve their communities better and meet their needs better. But some hospital groups have complained that this is not being implemented properly. I would like to hear what HCFA's plans are to improve this program.

Mr. HASH. One of the issues that has been raised, Mr. Camp, is the time required for physicians to respond to a critical access hospital. There was an early proposal for a 30-minute response time. We ended up actually permitting a response time for these critical access hospitals providers of up to an hour. I think that has gone a long way to addressing the major concern that I believe was raised with respect to how we were implementing the critical access hospital program.

If there are other areas that you are aware of that I have not mentioned, then we should look at them and try to address them.

Mr. CAMP. Well, specifically, the education and training that has been provided, or may not have been provided, to fiscal intermediaries to implement this program, what plans do you have for education and training?

Mr. HASH. I believe we have been working with the States through those contractors. A key component of this, as you may know, is that each State has to establish a State-critical access hospital plan. Once having established that plan, and I think not all States have completed that work yet, then in fact the institution can be designated and paid according to the rules for critical access hospitals.

If there is some confusion about the role of the contractors, the fiscal intermediaries, I would like to work with you and your staff to get clarifying information out there.

Mr. CAMP. Thank you.

My second question is really regarding visiting nurse associations and home care providers. I have been hearing from some very reputable home care providers in mid-Michigan, the area I represent, who have been responsible—and I understand the fraud and abuse problems we have been trying to address, but who have been responsible providers.

They have had a history of compliance, they have done well in their businesses, their denial rates are very low, but they are being crushed by the regulatory and administrative burden and the cost of responding to numerous audits and the paperwork they receive.

What can you tell me about what I can say to these responsible home care providers that are really burdened? And there are many other factors that are burdening them, but particularly this regulatory burden.

Mr. HASH. I would say that we, too, have been trying to work closely with the home health agencies, including the Visiting Nurse Association, throughout the country. We recognize that for many of them the changes included in the BBA have been difficult to adjust to. That is why, as I mentioned in my testimony, we have tried to be very lenient with respect to repayment plans associated with interim payment system overpayments.

We have also tried to scale back, or phase in more slowly, some of the other requirements that are imposed through the BBA. For example, we have cut back on the time for implementing the surety bond requirement and have reduced the level of that requirement. We have eliminated sequential billing, which was a procedure that was causing cash flow problems. We are phasing in a billing requirement related to 15-minute increments of home health visit times.

We have tried to take a number of steps to, in effect, address those kinds of problems that have slowed down either their cash flow or, in cases where they have found there is a substantial overpayment, that they need to repay.

Mr. CAMP. OK. Thank you for your comments.

Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Louisiana, if you have not voted, you are probably going to be pressured for time.

The gentlewoman from Connecticut has already inquired. If you want to continue the questioning, and then as soon as someone else comes who has not, you will recognize them. I appreciate that.

Mrs. JOHNSON of Connecticut [presiding]. Yes, sir. Trust me, Mr. Chairman.

I am pleased to have this opportunity to visit with you, Mr. Hash.

On the hospital outpatient payments, first of all, you do recognize the need to implement this change in a more gradual fashion. I appreciate that. Of course, as you increase benefits payments for some hospitals, you decrease payments benefits for other hospitals. Can you tell me which groups of hospitals are going to be hurt by your adjustment?

Mr. HASH. One thing to say at the outset, all of the estimates people are talking about now are related to our proposed rule. We got a very large number of comments, and we are in the process of substantially revising that proposed rule, so the impact state-

ments and analyses will all be very different, I can assure you, than they are now.

But, based on the impact analysis that we did on the proposed rule, the most heavily impacted institutions from the scheme we laid out in the proposed rule were low-volume rural and urban hospitals, teaching hospitals, and cancer hospitals.

Mrs. JOHNSON of Connecticut. Those are the ones you are going to help?

Mr. HASH. That is our intention, that is correct.

Mrs. JOHNSON of Connecticut. My concern is that, coming from a State that has no rural hospitals, because we realized early on we could not tolerate that designation, and most of my hospitals in smaller communities are not teaching hospitals, are they going to be further cut then? Because what I am saying is it does not fall rationally, it does not fall by category of hospital, necessarily.

I have seen numbers that show that some people are going to experience a 50-percent cut in reimbursements and some a 3 percent or 5-percent cut. I think instead of categories of hospitals, we should be looking at hospital impact.

Mr. HASH. We will, Mrs. Johnson. That is why I said, on the low-volume problem, which I think may be a problem for many of your own institutions, they are not necessarily rural but they are small and they have low volume, that is why we need to address the impact specifically on an institution that has a relatively small number of cases.

Mrs. JOHNSON of Connecticut. Good. I look forward to working with you on the details.

I assume, as you work on this PPS for outpatient, you are going to recognize the extraordinary cost of drugs associated with outpatient care. In just my home town hospital, the cost of drugs over the last 2 years has increased 43 percent. If we fail to acknowledge that in the outpatient PPS we will truly damage our health care system.

Mr. HASH. We, too, have heard that and looked at the data and recognize that our own data for the original proposal was not adequate in terms of a reflection of the prices of many important drugs that are provided in the hospital outpatient setting. We have hired an outside contractor to gather data on prices and use. We want to use that to refine our final rule.

Mrs. JOHNSON of Connecticut. That is good. Thank you.

I assume Mr. Cardin has not had a chance to question. I now recognize Mr. Cardin.

Mr. CARDIN. Thank you, Madam Chairman.

Let me welcome Mr. Hash to the committee.

Mr. HASH. Thank you.

Mr. CARDIN. Let me just express my first concern. That is, I think the circumstances on access are very serious in some areas that need addressing by this Congress if it cannot be done administratively. I certainly hope many of these issues can be done administratively. To the extent that we can be helpful in accomplishing those objectives I agree with the Chair we should work together.

If there are areas, and I know there are, that require legislative assistance, we need to act in this Congress. Circumstances are get-

ting very serious I know in my State of Maryland and I think around the Nation.

I am glad to hear you mention the therapy cap and the need for relief. That will require legislative attention, since it is established by law. I think the impact that the therapy cap is having, along with the changes that we have made in the skilled nursing facility reimbursements, is having a compounding impact on high acuity patients particularly that need nursing services.

For the life of me, I cannot understand why we impose the therapy cap, to start off with, other than to save money. I cannot think of a policy reason for it.

Second, it is unfair in the way it is implemented. The Chair pointed out that, because of your ability to track these expenses, there are some beneficiaries that are exceeding the cap, and you cannot determine that, but yet, a beneficiary that is in a nursing facility cannot escape the cap. That is not fair to, again, a high acuity patient.

I think it really cries out for relief now. I hope we will all work together to figure out a way to deal with that in a way that is fair, and I can give you the names of people in my congressional district that, as early as March of this year, were up against the cap. That is not right. I think that is one area we truly need to work together on.

Mr. HASH. We definitely join you in that concern.

Of the settings where we are particularly concerned about access to therapy services, it is those patients who are in nursing homes where we want to focus our attention.

Mr. CARDIN. Good. I am glad to hear that.

Let me also, please, raise a different view on the HMO problems on Medicare+Choice. Last year in Maryland, before we had the Medicare+Choice, we had eight HMOs that were providing coverage to seniors in our State. We are now down to four HMOs. We used to have HMO coverage in every county in our State. Now in most of the counties of Maryland you cannot get—a senior won't be able to get an HMO effective January 1.

Then in our more populous areas, the most popular HMOs requested—and today is October 1, so it is a day of decision, and I assume they will be able to charge our seniors now $50 a month for the services that were without additional fee in the current year.

All that is happening, and I don't think it is fair to say that what we did in the Balanced Budget Act has not had an impact on that. In our State, we don't have a problem of network. There are plenty of networks in those lower counties. It is the fact those reimbursement levels are not allowing those HMOs to continue. I do think we have a problem, and it is affecting access.

As you and I both know, the real service area that is going to be impacted the most is the lack of coverage for prescription drugs.

Mr. HASH. Absolutely, Mr. Cardin. I didn't mean to say that the BBA changes are not related at all to these decisions. I just wanted to suggest that, for many organizations, there are a multitude of factors that went into their decisions about whether to drop their contract or to reduce their service area.

But you are absolutely right. The consequence, from the beneficiary point of view, is loss of access in most cases to additional benefits or savings from out-of-pocket expenses associated with joining an HMO. That is a serious issue and one that we are very concerned about.

I think, in the case of Maryland, that you and I have talked about, it is a situation in which the growth rate in the payments to managed care plans in those areas was growing much, much less rapidly than it had before the BBA came into place. If those organizations were going to continue to offer, both in urban and rural areas, the extra benefits they wanted to offer, they were finding difficulty financing those extra benefits based on the payments they were receiving. I think, in those cases, payments played a significant role. But, as you know, there have been other factors where they pulled out of their commercial business as well as their Medicare business in the same areas.

Mr. CARDIN. My time has expired. There are many other areas we have dealt with in the BBA Act. I want to thank you for your cooperation in looking at each one of those.

Mr. HASH. Thank you.

Mrs. JOHNSON of Connecticut. Mr. Ramstad.

Mr. RAMSTAD. Thank you, Madam Chair.

Mr. Hash, I would like to address a question, some questions related to the Maron Act. I want to specifically address an issue that I know is important to many, many seniors in Minnesota and across the Nation. That is, ensuring that frail, elderly seniors maintain access to the critical comprehensive health care they are currently receiving.

I know HCFA recognizes how successful and popular the EverCare program is with current enrolled beneficiaries. I am not sure some of your colleagues at HCFA have recognized the significant cost savings of this program to the Medicare system. Trust me, they are real. I have all the empirical data in the world to support this. EverCare I think shows that the market does react to and can react to provide not only quality health care but can save money and certainly reduce hospitalizations. That is exactly what EverCare has done.

Do you agree with that?

Mr. HASH. As you may know, I have been working closely with folks at EverCare about their concerns, and we want to move forward with them.

The issue that I think we have still—definitely are devoting a lot of energy and resources to is designing a payment system that appropriately accounts for the kind of patients or the kind of individuals they are enrolling there. That is our joint call.

We are committed to doing the necessary work to ensure their payments are appropriate for the health status of frail elderly enrollees in Medicare+Choice plans.

Mr. RAMSTAD. I certainly appreciate that spirit of cooperation that you are displaying today. Certainly you do understand the grave impact that the interim risk adjustor will have?

Mr. HASH. That is why we have delayed it for them. Our intention is to examine a risk adjustor that better reflects the functional status of the individuals enrolled as well as the health status indi-

cators. For that kind of population, you may need to take into account both their ability to carryout the activities of daily living as well as what their health status is. That is a key part of what we are addressing and analyzing in our ongoing work.

Mr. RAMSTAD. Is it your intent to exempt it beyond one year?

Mr. HASH. We want to see if we can come to an agreement on a risk adjustment methodology that appropriately recognizes the health care needs of their enrollees.

Mr. RAMSTAD. You are willing to work with Mr. Cardin? You are aware of the legislation Mr. Cardin and I have introduced concerning the EverCare program?

Mr. HASH. Yes, I am. Our view is that we have a great deal of optimism about being able to work out a risk adjustment methodology that should be satisfactory to them and to us as well.

Mr. RAMSTAD. Are you talking about all EverCare or just demos?

Mr. HASH. It would obviously be for the frail elderly programs around the country, of which EverCare is one.

Mr. RAMSTAD. So you are willing to work with us to resolve the problems to take care of all the frail elderly seniors?

Mr. HASH. We definitely want to do that. As I say, I think a key issue, unless I have misunderstood it, is making sure that we properly analyze adjusting their capitation rates to reflect their functional status as well as their health status.

Mr. RAMSTAD. Again, I appreciate your willingness to work specifically with reference to EverCare, because that is so important to many, many elderly frail seniors in Minnesota. They just—it would be a real shame, a real crime, if they were to lose this health care option that they really like, that they have chosen, that they have come to rely upon. So you will work with us to save this health care option?

Mr. HASH. Yes, sir.

Mr. RAMSTAD. I yield to Mr. Cardin.

Mr. CARDIN. I appreciate that. My time had run out. I was going to bring up that issue.

I very much appreciate your response, Mr. Hash. It is not a Minnesota problem or a Maryland problem. It is a problem in many parts of the country. We are saving money for the system in these programs dealing with our frail elderly.

Mr. HASH. Yes.

Mr. RAMSTAD. Thank you again, Mr. Hash. I am looking forward to getting this done in the next couple of weeks before we go home.

I also want to, in the remaining seconds, ask you a question on inherent reasonableness authority.

By the way, I assume I can submit these questions and you will answer them in writing?

[The following questions submitted by the Hon. Jim Ramstad and the Hon. Michael Hash's responses are as follows:]

Questions from Hon. Jim Ramstad and Hon. Michael Hash's Responses

INHERENT REASONABLENESS

Question 1. It is my understanding that HCFA received numerous comments in the spring of 1998 on its interim final regulation setting forth its IR process and criteria. The comments raised substantive concerns about the rule, including concerns about HCFA's use of an interim final rule, adopted before the opportunity to comment, for such an important subject. In March, Chairman Thomas asked the

GAO to examine HCFA's use of the IR authority. Why did HCFA decide to initiate a new IR action before responding to the important concerns raised about the 1998 interim final rule and before the GAO report?

Answer. It was necessary and appropriate for us to issue the inherent reasonableness regulation in final with comment for several reasons. The new regulation was merely announcing what the statute authorized as a procedure change. It did not change the already existing regulation, except for certain provisions specifically provided for and clearly stated in the statute. The intent of these changes was to simplify the process for making inherent reasonableness determinations. And we believe it would have been irresponsible to delay implementing this statutory provision and to perpetuate grossly excessive or deficient Medicare payments.

In response to Chairman Thomas' letter, in which he asked the GAO to examine HCFA's use of inherent reasonableness authority, we indicated that we would delay final action on the durable medical equipment inherent reasonableness proposal until we had the opportunity to review the GAO's report. As a result, all carrier proposed adjustments relating to inherent reasonableness have been put on hold. While we have issued a national proposal, we have no plans to issue any final determinations before we have reviewed the GAO report.

Question 2. August of this year, HCFA proposed reductions in payments for certain durable medical equipment and prosthetic devices based on data obtained from the VA. In doing so, HCFA did not investigate the prices set through the marketplace.

While an attempt was made to reconcile the differences between the VA system, a "device wholesaler," and the Medicare program by applying an adjustment to the median VA price, there is concern that this approach is flawed. The concerns derive from the fact that the ways in which manufacturers participate in and sell to each program are significantly different.

For example, a constituent medical device company has told me that the proposed markup does not adequately account for the high administrative costs associated with Medicare claims processing. Given the burdensome documentation requirements, they employ 26 full-time staff to process Medicare claims—but less than two employees handle sales to the VA program. This represents a 13-fold increase in administrative support per device sold. Other burdens that differentiate the two programs are: the average payment cycle, which is 20–30 days for VA compared to 4–5 months for Medicare, and the mandatory rental program for Medicare patients.

What specific considerations were used in applying the adjustments to the VA payments for determining the Medicare levels? Is it truly appropriate to use the VA system as a basis for making these determinations?

Answer. The Veterans Administration (VA) pays for the same type of medical equipment used by Medicare beneficiaries. In many instances, the VA is able to purchase equipment for significantly less money than Medicare can because the VA uses a competitive bidding methodology. After considering the GAO's report comparing the oxygen payment rates of the VA and Medicare, Congress lowered Medicare's payment rates for home oxygen by 30 percent and, thus, gave support to the use of VA payment amounts as an tool for determining whether Medicare's fee schedule rates are reasonable. In the case of home oxygen, the VA's payment amounts were less than half of Medicare's rates. The GAO found that VA's use of competitive pricing, rather than differences in the cost of doing business, contributed significantly to the differences in VA and Medicare payment amounts for oxygen.

For purposes of comparing VA and Medicare payment amounts, we proposed in our current national inherent reasonableness notice to increase the VA's median payment amounts by a mark-up factor of 67 percent. The mark-up percentage is based on data furnished to us by manufacturers as part of our medical device coding process.

In developing our current inherent reasonableness notice, we did consider suggested wholesale and retail price lists. However, because of Medicare's predominant role in purchasing health care items, these "marketplace" prices may not necessarily be reflective of a competitive market, but rather how much Medicare is willing to pay under the fee schedule methodology that has been in place for over 10 years.

Question 3. The IR statute sets forth a more rigorous notice and comment procedure for adjustments over 15% to ensure that such significant adjustments are based on appropriate data and are thoughtfully considered. The statute states that such changes are measured over the course of a year to prevent HCFA from making multiple adjustments in a given year without following the more demanding process.

The agency, however, has adopted a policy that allows it to avoid that more rigorous process merely by spreading out over successive years any adjustments of

more than 15%. HCFA has employed that policy more than once in its IR actions to date. For example, in 1998, HCFA proposed reducing lancets by 20% through a 15% adjustment in the first year and 5% in the second.

It appears as HCFA is violating the IR statute Congress established. Please respond.

Answer. As we indicate in our interim final rule, the statute clearly provides two options for making inherent reasonableness adjustments. When an adjustment is greater than 15 percent in one year, procedures similar to those in place prior to the passage of the Balanced Budget Act (BBA) must be followed. If the adjustment is 15 percent or less in a year, the BBA provided a more streamlined process and allows either the Secretary or the carriers to propose such a change. The BBA does not prohibit reductions of 15 percent or less in successive years.

Outpatient PPS

The BBA requires HCFA to establish a prospective payment system for most hospital outpatient services furnished on or after January 1, 1999. HCFA staff has indicated that new technology and medical procedures will be assigned to the lowest payment of the Ambulatory Payment Categories (APC) related to the treatment or condition.

Question 4. Won't this practice create financial disincentives for both providers to make the latest medical technological advances available to their patients and for manufacturers to avoid and/or delay developing more innovative technical advances in general?

Answer. We will be making significant changes in how we plan to categorize new technology and medical procedures under the outpatient department (OPD) prospective payment system (PPS). In cases where it is possible, if new technology items are similar clinically and in cost to existing items, a current appropriate APC can be used for placement of a new technology item. In instances where there is no match with an APC clinically and on the basis of cost, we expect to use a set of cost-related APCs for new technology items. These APCs would initially contain only certain items that are new since 1996, and therefore not reflected in the 1996 bills used to develop the PPS.

When a new item must be placed in an APC and there is not an appropriate existing APC, we will use one of the cost-related APCs to set the payment rate for a period of time (perhaps 2 to 3 year) while better data about actual costs is collected. Placement in the appropriate temporary APC would be based on the best available data, such as a percentage of AWP for drugs, or cost data supplied by device manufacturers for devices. After 2 to 3 years, the items would be moved to a permanent APC based on both cost and clinical considerations.

Question 5. When the BBA was passed, 1996 data was the most recent available to use in calculating APC payment rates. We agreed to this year because we understood the new PPS system would be implemented in 1999—approximately three years later. However, given HCFA's announced one-year implementation delay, there is now a four-year window between the actual year of the data and implementation. Will HCFA use more recent data—such as data acquired in 1997, or preferably 1998, if it is available—in refinements to the APC payment categories to more appropriately reflect advances in medical technology in recent years?

Answer. The law requires the Secretary to use claims data from 1996 and data from the most recent available cost reports in order to establish relative payment weights under the OPD PPS. In developing the PPS for implementation in 2000, we are continuing to use claims data from 1996, as stipulated by the law, but have used more recent 1997 cost reports, if they are available.

After the PPS is implemented, we are required annually to review and revise the groups and the relative payment weights on the basis of new cost data and other relevant information. When the new payment system is in place and hospitals begin to code for services furnished as required under the new system, more recent data will become a valuable tool that is used to complete this annual review and make necessary revisions.

Question 6. The HCFA proposed regulation forces thousands of outpatient procedures into approximately 340 APC groups. With such a low number of APCs, it is virtually impossible to achieve comparability between clinical and relative resources within an APC group. I am told some procedures will see cuts of up to 56% under the proposed group compression. Does the BBA specify 340 APC groups, or does HCFA have the authority to increase the number of APC groupings so that procedures that are clinically similar and share similar resource costs are grouped together more comparably?

Answer. The BBA did not specify 340 APC groups. The law allows the Secretary to establish groups of OPD services within a classification system so that services classified within each group are comparable clinically and with respect to the use of resources.

A number of concerns have been raised regarding the variability within APCs as included in the proposed rule. In developing the final rule, we plan to make significant revisions to the APCs making them more homogeneous. We will shift procedures among APCs and create new APCs when warranted. These changes should reduce the impacts seen for many items and procedures.

COMMUNITY NURSING ORGANIZATIONS

Question 7. It is my understanding that HCFA's study only used data from the "start up" years, from 1994–1996. Why does HCFA refuse to use the data for years beyond 1996, and has HCFA made a copy of its final report on CNOs available for public review?

Answer. The CNO demonstration project and evaluation were designed to randomly assign beneficiaries seeking enrollment in the demonstration project into one of two groups, a control group and a treatment group. The treatment group consisted of CNO enrollees, while the control group received care through the traditional fee-for-service Medicare program. The CNO sites provided data to us covering a 4-year period from 1993–1997. We believe this is a sufficient time period for collecting data and conducting a sound evaluation of the CNO demonstration

In 1997, the CNO sites sought to transfer the control group members into the treatment group. We advised the CNO sites that doing so would invalidate any future data that might be collected because the control group would no longer be available for comparison purposes. Contrary to our recommendation, the CNO sites transferred the beneficiaries in the control group into the demonstration treatment group, thus nullifying the validity of any future data collection efforts.

We expect to receive the final independent evaluation report of the CNO demonstration shortly. Once we receive it, we will provide a copy and a summary of the report to Congress and will make them available to the public.

Question 8. As you know, the CNOs have concerns about the data set used in the HCFA study and conducted their own study, focusing on high cost and high volume services, including hospitalizations, ER utilization, SNF stays and outpatient/physician visits. Have you reviewed this study? Why does HCFA feel its approach was the preferential study design?

Answer. We have reviewed the CNO's study design. Their study examined specific components of the demonstration project in isolation and did not evaluate the program-wide impact of the demonstration. We believe that our assessment is preferable to the CNO sponsored study. Our assessment examined the impact of the demonstration on the Medicare program as a whole and was performed by independent reviewers who were not biased towards a particular outcome.

Question 9. HCFA staff has indicated that studies have not found that the CNOs improve quality of care or reduce health care costs for enrolled seniors. However, in two recent national studies, the CNOs have been nominated by experts in the field and selected as "best practice" programs for care of older adults and care coordination (Mathematica Medicare Coordinated Care Project, Best Practices Assessment and Demonstration Design, 1999, and the Robert Wood Johnson Foundation and Ross Laboratories Study of Innovative Programs, Innovative Healthcare for Chronically Ill Older Persons: Results of a National Survey, American Journal of Managed Care, 1999). I am also aware that the Arizona CNO has monitored the health status of new enrollees since 1998, finding that SF–36 Health Status Scores were significantly better after one year in all areas.

On the issue of cost, I am aware that while the HCFA evaluation found that combined, the CNOs provide comparable quality services at a slightly higher cost than traditional Medicare, a closer look at the data found two locations yielded cost savings. The total cost of services per enrollee for the Arizona CNO treatment group was $151.13 less than the control group, and the MN CNO cost Medicare $63.00 per member per month less than the control group for total hospital, ER, post-acute rehabilitation and outpatient services by the third year of the demonstration.

The CNOs utilized their study results to identify "best practices" that can be adopted at all locations and reduce overall costs. Since the CNOs deliver quality care and can reduce costs, why does HCFA so strongly oppose this Medicare beneficiary option, especially since they are so popular with enrollees?

Answer. According to its findings of our independent evaluator, the CNO model does not cost less than traditional Medicare and, in fact, increases Medicare trust

fund outlays. In addition, our evaluator found the CNO program had little or no positive impact on the well being of beneficiaries. As a result of these findings, we do not believe the CNO model merits replication in the Medicare program as a whole.

You mentioned the Mathematica Policy Research, Inc. (MPR) study. MPR reviewed best practices for coordinating care in the private sector. In order to identify as many successful programs as possible, they cast a wide net. They published announcements in journals and the Federal Register as well as sent letters to certain programs. MPR encouraged programs to submit information about their care coordination practices and any subsequent reductions in program costs.

The MPR review was not a formal evaluation of the CNO program, however. It was a survey that relied entirely on self-reported information. MPR did not utilize a comparison group and did not perform any independent data collection or analysis. The MPR review simply described common features of successful programs, and did not identify specific programs as "best practices." You also mentioned the Study of Innovative Programs, sponsored by The Robert Wood Johnson Foundation and Ross Laboratories. This study was also a survey and not a formal evaluation of the program.

In contrast to these two surveys which relied on self-reported data, our evaluation was based on a carefully designed research protocol that involved random assignment of participants to treatment and comparison groups and collection and analysis of data by an independent third party. We believe our evaluation is the most appropriate vehicle for assessing the actual impact of the CNO demonstration.

With respect to cost, our evaluation indicates that the treatment groups in the CNO demonstration were more costly than the comparison groups overall. The lower costs in selected areas, as cited by the American Nurses Association (ANA), were offset by higher costs in other areas that were not cited in the ANA's report.

Mr. HASH. That is correct. I will be happy to.

Mr. RAMSTAD. I know a number of members have sent letters and I have had an HHS staff member in my office to talk about some of the things that HCFA is doing with the inherent reasonableness authority Congress gave it.

I see my time has expired. I am very, very concerned about this authority. I will submit the questions in writing. Thank you, Mr. Hash.

Mr. HASH. I would be happy to respond, Mr. Ramstad.

Mrs. JOHNSON of Connecticut. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Madam Chair.

Mr. Hash, to your knowledge, is there anything that HCFA does that is not authorized by law?

Mr. HASH. I hope not.

Mr. MCDERMOTT. Basically, everything you do is following laws that we wrote, right?

Mr. HASH. To the best of our ability, yes, sir.

Mr. MCDERMOTT. On the issue of unbundling or anything else, we are going to have to take the responsibility for unbundling and let that happen, whatever happens?

Mr. HASH. We want to work with you and be a partner in addressing those kinds of issues, yes, sir.

Mr. MCDERMOTT. If we unbundle in one area, do you think we will get a request to unbundle in other areas?

Mr. HASH. I think the critical challenge here, Dr. McDermott, is in fact that we make the changes, whatever changes we make, on the basis of the best evidence that we have and we target those changes to where we think the need is greatest.

Mr. McDERMOTT. I have some concerns in that whole question of unbundling, having been through this fight a number of times both here and in the State legislatures.

I was not here when Mr. Lewis asked his question about the issue of your appropriation, but I understand that the Appropriations Committee cut back by $70 million the dollars, the amount that was spent for anti-fraud adjustments. I have real concerns about this, if you are serious about saving money in the process.

My understanding is that GAO says that about half the money that has been saved, actually more than we expected would be saved, has been from the anti-fraud activities. It is kind of across-the-board stuff, like coding up, those sorts of things. Tell me about what your feeling is about then turning around and giving the providers an increase, when most of the savings we have gotten has been from cutting out the fraud and the waste, fraud and abuse in the coding system, or other similar kinds of ways.

Mr. HASH. I would agree with what you said, Dr. McDermott.

As I said to Mr. Lewis earlier, these cuts are really devastating. They are, in my judgment, penny wise and pound foolish. There is abundant evidence that every Federal dollar invested in fraud and abuse is returned to the taxpayer in the form of recoveries in multiple amounts over what the investment is. When Congress set up the fund for fraud and abuse, they set it up in a special category, in a mandatory appropriation, and guaranteed stable funding for this important and critical activity. I think this would be definitely a serious step backward.

Mr. McDERMOTT. What possible explanation could one make for why the majority would want to cut a program that cuts out fraud and abuse and has been effective in more than dollar-for-dollar numbers? What explanation could there be?

Mr. HASH. I am sorry, Dr. McDermott, but I don't really have an explanation for you. I am just as shocked and disappointed about this as you are.

Mr. McDERMOTT. It would seem like they are letting the pressure off, would it not?

Mr. HASH. I would think so. It would have that effect, yes, sir.

Mr. McDERMOTT. And so if people know that nobody is going to come around and look, they can go quite a ways until they figure, well, we had better tighten up a little?

Mr. HASH. I would agree with that, Dr. McDermott.

Mrs. JOHNSON of Connecticut. Would the gentleman yield on that?

Mr. McDERMOTT. Sure.

Mrs. JOHNSON of Connecticut. One of the big problems is that the fraud and abuse people, the Inspector General, is totally ignoring directives from fiscal intermediaries to providers and charging them with fraud and abuse when they were acting in conformance, so there are some very serious problems in what the Inspector General is doing, I would maintain.

Mr. McDERMOTT. It is in our position then, as I hear that, that the money was unfairly taken from them?

Mrs. JOHNSON of Connecticut. Absolutely. In some cases, no question about it.

Mr. McDERMOTT. So the answer to that is then to cut out the fraud and abuse program?

Mrs. JOHNSON of Connecticut. That is not the answer, but to say that there are no problems with the fraud and abuse program would be really to close your eyes to some of the serious misactions of the Inspector General. We certainly needed it, we passed it, I am glad it is there, it is saving money, but there are serious problems in what the Inspector General is doing, in some instances.

Mr. LEWIS. Mr. McDermott, would you yield, sir?

Mr. McDERMOTT. Surely.

Mr. LEWIS. Mr. Hash, you are telling the Committee if you have this dramatic, unbelievable cut to be able to do something about abuse and fraud, you are not going to be able to do the job? It is not a case of the chicken and the egg or the egg and the chicken, is it?

Mr. HASH. It would have a definite effect on reducing our efforts that have been very successful in combating fraud and abuse, no question about it.

Mr. McDERMOTT. So it is the end of your testimony. You would say you did not do anything that the law did not require you to do? You have been accused here of going beyond or somehow misapplying the law. Is that true?

Mr. HASH. We have been trying to apply the law as best we could, Dr. McDermott.

Mr. McDERMOTT. Fine. Thank you.

Chairman THOMAS [presiding]. I believe the operative word is "trying."

Does the gentleman from Louisiana wish to inquire?

Mr. McCRERY. Thank you, Mr. Chairman.

Mr. Hash, as you are well aware, the scientific community sometimes moves faster than the bureaucracy. They develop new treatments, new drugs, and we certainly all want for our Medicare recipients to have access to those in a timely fashion.

Under the new APCs, what is your procedure, your process, and the timeline that you expect for making adjustments to the APC to take into account the introduction of new procedures, treatments, drugs?

Mr. HASH. Mr. McCrery, that is an area that we are reviewing for the publication of our final rule. But I can tell you, based on the comments we have received and the folks we have met with on this very issue of getting advancements quickly to the bedside or to the clinic site for our beneficiaries, is a very high priority of ours. We are working to address that in the most timely way we can in our final rule.

I will tell you that, as you would see from our proposed rule of last year, we would immediately allow the assignment of codes to new advancements, and then under the process that we use, it is basically to collect the data about the cost, the charges for new advancements and the use of them over a period of at least a year so then we can properly assign them, in the case of an inpatient DRG, to the proper DRG, or, in the case of the outpatient payments, to the proper APC category.

We want to make sure that process is expeditious, but is also prudent that we do it on the basis of a database of charges have accrued over a year.

Mr. McCrery. You expect sometime in the near future to publish some sort of regimen for that process?

Mr. Hash. Yes, we will be. Our final rule to implement the hospital outpatient PPS will be coming out at the end of this year, and that will include specific procedures for how new things are coded and treated in our outpatient payment system.

Mr. McCrery. OK. Thank you.

Let's talk for a minute about this phenomenon that we have experienced with the savings in Medicare now projected to be roughly double what we estimated when we passed the BBA. You have said in your testimony that there are a lot of other factors that account for that. Have you been able to isolate those factors and quantify them?

Mr. Hash. No, Mr. McCrery, we have not. But based on our own actuary's assessment of the changes in their estimates for Medicare outlays, and, as you know, based on reports from the CBO, both have attributed the slow-down in the growth of Medicare expenditures to fraud and abuse activities in particular, to changes or lower inflation because of a strong economy, and, to some degree, the changes of the BBA, which have slowed down, in some cases, payment processes because we have changed them a lot.

All of those factors work together, plus the BBA policies themselves, and have had this combined effect of changing the rate of growth in Medicare expenditures.

Mr. McCrery. The changes in the rate of payment would be anticipated now in the estimates for the next 4 years, the next 3 years, I guess. So that really should not enter into the discussion of why the 5-year figure has doubled, basically.

Of the other reasons, have you been able to come up with a percent of the total increase that they constitute?

Mr. Hash. We have not, Mr. McCrery.

Mr. McCrery. Don't you think that would be worthwhile for us to try to isolate what the changes in BBA account for in terms of that increase in savings, so that we would get a firm handle on how wrong we were in our estimates with respect to the spending cuts for Medicare?

Mr. Hash. As you can appreciate, this is—and I am certainly not an actuary or estimator, but this is an exceedingly challenging area, and one, as I understand it, that—the estimates, for example, that were made about the impact of the BBA in August 1997 were the best estimates that could be made at that point in time. But as time goes on and data come in and more information is available, there are new point-in-time estimates. You cannot compare them in the sense of, oh, those very same BBA estimates are locked in for the full 5-year period and that anything else that occurs is outside of that.

It is very difficult, and I think my colleagues who are following me on the next panel would be much more qualified to answer this question of how you distinguish the factors that account for decreases in Medicare expenditures.

Mr. McCrery. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Hash, you may be acting administrator, but you are learning fast. You just pass that buck. We appreciate that.

Does the gentlewoman from Florida wish to inquire?

Mrs. THURMAN. I do, Mr. Chairman. Thank you.

I want to go back to the APC issue a little bit. Is it my understanding, then, that you actually can do these changes administratively?

Mr. HASH. Are you referring to——.

Mrs. THURMAN. Drugs, new technologies?

Mr. HASH. We have a great deal of discretion in the design of the outpatient payment system; and based on the comments we have gotten on our proposed rule, we are anticipating making significant changes in the design of the payment system when we publish it finally.

Mrs. THURMAN. You think you can take care of the issues where new drugs are coming on the market and are costing more than what they would be getting today under the old medicines?

Mr. HASH. Right. I do believe we can, Mrs. Thurman. That is one of the reasons, I think, we felt that the proposed rule did not adequately reflect the cost of some new drugs, particularly those that have come on in recent years. It was our decision to hire an external contractor to go out and actually gather real prices in current time on selected drugs that are very important and are high-cost to Medicare beneficiaries.

Mrs. THURMAN. Then within the new technology area as well?

Mr. HASH. That would be right. Similarly, there are important issues about how new devices, and those kinds of things, how they get coded and how quickly they get incorporated into the outpatient payment system.

Mrs. THURMAN. OK.

Mr. Hash, in our GAO report we are going to be told that in the area of some of our home health care issues that they found little evidence that beneficiary access to services was inappropriately curtailed. Actually, that may not be—yes, GAO. We have a lot of home health care issues in our area. I have some questions to ask you. Has HCFA seen the higher-cost patients losing access to home health care?

Mr. HASH. We don't have any systematic evidence about that, but of course we have received reports that those kinds of patients may be having some difficulty. In fact, we met with a number of advocacy groups on these home health access issues.

One of the things that was reported to us time and time again was that home health agencies would tell beneficiaries that they could not get any additional services because they had reached their cap. There is no individual beneficiary cap. We have tried time and time again through communication with home health agencies and, of course, with beneficiaries, to the best we can, to impress upon them that no agency would be correct in telling a Medicare beneficiary that they have exceeded a cap that is a per person cap. That is just not correct or accurate.

Mrs. THURMAN. Have we noticed—I am concerned that we are cost-shifting now into a higher cost within nursing care admissions. Have we seen any evidence of more admissions into nursing care?

Mr. HASH. Not yet. In fact, actually both the admissions to nursing homes and the days, the stays, are actually continuing to decline.

Mrs. THURMAN. OK. What about emergency admissions? Or rehospitalization?

Mr. HASH. I don't have that data, but I would be happy to try to get something for you to address that.

[The response follows:]

Response by Michael Hash to a Question from Hon. Karen L. Thurman

Question. What about emergency admissions? Or rehospitalizations?

Answer. We have asked the HHS Inspector General (IG) to conduct a study on emergency room use and hospital readmissions for home health patients following the passage of the Balanced Budget Act. We are working with the IG to provide the necessary data to determine if these patients are returning to the hospital more frequently than in the past.

We have looked at hospital discharge rates, and we have not noted that there has been a slowdown in the movement of patients out of the hospitals, either to nursing homes or to home health services, as opposed to a hospital.

Mrs. THURMAN. Besides just maybe the skilled nursing homes, what about those that would be long-term care?

Mr. HASH. I think actually, because the standards for admission, if a patient doesn't need a skilled level of care, or are lower, then our expectation would be that those are patients that are probably not being as directly impacted by the BBA as those patients with a higher acuity level.

Mrs. THURMAN. I just want to add and echo the sentiments of many of my colleagues up here on the physical therapist issue, particularly with Mr. Cardin on this issue of outpatient hospitals getting it, and the nursing care. That is a very difficult situation. Is that something we need to do or, again, is that something you can do administratively?

Mr. HASH. I believe that is a legislative issue, but one on which we want to work and provide help in identifying how to address that issue.

Mrs. THURMAN. Thank you.

Chairman THOMAS. The gentleman from Pennsylvania, does he wish to inquire?

Mr. ENGLISH. Thank you, Mr. Chairman.

Welcome, Mr. Hash. I noticed on page 4 of your testimony that you extensively outlined what you have proposed to do as far as rural hospital reclassification, to address the fact that many rural areas have traditionally been poorly reimbursed for certain procedures.

I noticed, however, in your discussion of the Medicare Medicare+Choice program you don't have a similar discussion of how Medicare+Choice reimbursements, based on some of those old, unilateral formulas, might be reconsidered.

I note in your discussion and exchange with the Ranking Minority Member that you testified that low reimbursements do not account for managed care exiting certain markets, in your view. Yet our experience in northwestern Pennsylvania with a product called Security Blue—and I know you are very much aware of this because your staff has met with my office, and I appreciate that—our experience with Security Blue has been that the Blues have been obliged to dramatically truncate the prescription drug benefit that they offer to seniors and are able to point to huge differentials within our region, a huge differential in how Medicare+Choice is reimbursed in Erie, Pennsylvania, Meadville, Pennsylvania, Sharon, Pennsylvania, versus Butler, Pennsylvania, which just happens, although it is neighboring on those areas, to also be neighboring on a high-cost area.

So my question is, how are you adjusting or considering adjusting reimbursement levels for Medicare+Choice programs in historically-low reimbursement areas, like the bulk of my congressional district?

Mr. HASH. I am glad you asked that question, Mr. English. A fundamental component of the President's Medicare reform plan is a very significant change in the way in which the Medicare program determines capitation payments for Medicare+Choice plans.

In short order, what it does is provide the opportunity for health plans to bid to the Medicare program what they believe to be their costs for delivering the services, so that we move away from the administered pricing formula that is established in the statute now.

In addition, I think, in the short run, the BBA itself intended, I believe, to narrow the range of disparity that was a reflection of those health care costs that produce such widely varying capitation rates under Medicare+Choice.

There is beginning to be a significant narrowing of those rates under current law. But I think our view is that we really need to move to a system that is more market-based in the determination of those capitation rates, and that is what is called for in the President's reform proposal.

Mr. ENGLISH. I will examine your proposal carefully.

Let me say, having, on a separate point, viewed your exchanges with the gentleman from Washington State and the gentlewoman from Connecticut, I wonder, how do you hold your fiscal intermediaries responsible for their actions when they make errors that have dramatic impact on providers, for example, a change in interpretation in a particular rule which has a dramatic impact on hospitals? You may even be aware of the one I am referring to. How do you hold the FIs responsible in cases like that?

Mr. HASH. Mr. English, we do, in fact, have performance evaluation standards built into the contracts that we have with fiscal intermediaries and carriers under the Medicare program. We are in a position to use performance, for example, does the contractor meet standards or not, and to terminate those contracts and give the business to other contractors who can meet our standards.

Mr. ENGLISH. In the case of a State that is facing a ruling which is leading to a massive retroactive demand for reimbursement, does that mean you are reassessing the role of your fiscal intermediaries in that State, and is that part of your internal operation?

Mr. HASH. The first step, in the particular case you are talking about, was to correct——

Mr. MCDERMOTT. Mr. Chairman, could we have a clarification? We are having a discussion about something most of us don't know what you are talking about.

Mr. ENGLISH. This has to do with a ruling with respect to DSH payments and the inclusion of general assistance population in the formula.

Mr. MCDERMOTT. All right. Thank you.

Chairman THOMAS. Let me clarify so you have a better understanding.

In Pennsylvania, for sure, and perhaps in one or more other States, the States have a payment structure which does not differentiate between the seniors and the general assistance program, and that the numbers that were counted for fiscal intermediaries required the counting, and it created a payment disparity. It was the fiscal intermediary who created that payment disparity.

HCFA is now indicating that particular States are responsible for what became overpayments because of the inclusion of people who would be on the ordinary Medicare count number.

The gentleman from Pennsylvania quite properly, I think, is indicating that he believes that the fiscal intermediaries are employees, in essence, contractual, with HCFA. And whose responsibility is it? And if, in fact, there was an error made, does that error, amounting to millions of dollars, now laid at the feet of Pennsylvania, constitute sufficient grounds for HCFA to examine the fiscal intermediaries' competence in terms of carrying out the program? And probably more importantly, is Pennsylvania going to wind up holding the bag? Is that a fair assessment?

Mr. ENGLISH. Mr. Chairman, that is a marvelous summary.

When you consider the retroactivity involved and the burden falling on providers that are the providers to some of the most indigent parts of our population, the finding of the fiscal intermediaries is truly extraordinary in this case.

Chairman THOMAS. And that in fact you believe you are not at fault, that it is the fiscal intermediaries—the fiscal intermediary who is at fault?

Mr. ENGLISH. Mr. Chairman, it was an established policy by which Pennsylvania was being reimbursed and other States.

Chairman THOMAS. That was the question.

Mr. Hash.

Mr. HASH. Yes. The situation in Pennsylvania, as I understand it, is, after an investigation of what had gone on there, it was ascertained that, in fact, the policy being applied, both in terms of what the State was reporting in terms of these days as well as what the intermediary was requiring in their audit of hospital cost reports, was not in conformance with the law. Under those circumstances, we don't have any other recourse other than to recover payments that are made that are not consistent with the authority in the law.

Mr. ENGLISH. Mr. Hash, as you know, in this case the law was not only established but had long been recognized as providing for this kind of reimbursement. That had been the existing policy. To change policy at some point and to go back in and retroactively im-

pose an enormous financial burden on a particular set of providers is unconscionable. I think you would have trouble finding any legislative intent to support it.

Mr. HASH. I can only say, in response, that it was never our stated policy. I agree with you that the intermediary contractor in this case improperly administered it. We never established a policy any different than the policy that is established in the law.

Chairman THOMAS. I would just tell the gentleman that his time has expired. I think we have laid it on the table sufficiently.

The idea that at certain times fiscal intermediaries are at fault and other times they are not is a policy which makes it very difficult for us to really understand and appreciate.

One of the reasons the gentleman from California and the chairman are cosponsoring a Medicare coverage and appeals bill which will, No. 1, shorten the time line so Medicare beneficiaries can have the same privileges most private health care plans have in adjudicating concerns, and that if, in fact, a fiscal intermediary conducts themselves in a particular way in a particular area and that problem is corrected, instead of just that individual in that area, as current law allows, getting that benefit, that benefit would then extend to all beneficiaries in all regions.

The harmony and the need to carry out a universal decision-making structure was the reason, and those people who follow this area fairly closely know that. If the gentleman from California and the gentleman from California cosponsor legislation, it is overdue and needed. That is sufficient in that area.

One last point, and then I will let you go. Then we will go to those people that you passed the buck to.

On page 14, you indicate that in the Medicare+Choice area that you cannot make the risk adjustment budget-neutral. You go on then to indicate the taxpayers who fund it would find this unacceptable, et cetera.

I just have to tell you that the broad-based taxpayer funding base for this proposal, the general fund, is certainly a broader base, and the burden carried by each of those taxpayers is significantly less than the dollars the Medicare beneficiaries have been paying out of pocket for the outpatient payment overcharge, which has been going on for more than a decade, in which there seems to be some examination of the possibility of making it budget-neutral.

In addition, the conclusion in that paragraph says that, "over the 5 years we are phasing it in, if health plans maintain their current mostly healthy beneficiary mix," my understanding is that the law requires these plans to sign up all comers. Are you suggesting there that the plans in some way screen so that they get a mostly healthy beneficiary mix? The "if" really concerns me. "if health plans maintain their current mostly healthy beneficiary mix," as though they have the ability to do that, did you intend that in terms of the way that was phrased?

Mr. HASH. Not at all, Mr. Chairman. What is intended by the "if" in that sentence is that if one is relying on the estimates of the impact of the risk adjustment on which the estimates are based, with no change in the composition of the enrollees in those health plans over the next 5 years, it could be that if that composition changes and there are, for example, beneficiaries with higher

health care needs who enroll in larger numbers than Medicare+Choice plans and then that impact will be considerably lower.

Chairman THOMAS. My concern is that we ought to look at every possibility to make sure that we don't have disruptions of services, including an examination of a potential budget-neutral adjustment for a short period of time.

I appreciate the administration's concern about taxpayers on one page, and the total ignoring of the beneficiaries' out-of-pocket costs that have gone on for more than a decade and very little sympathy for them, and the fact that perhaps this area might be budget-neutral as well. I am looking, as the gentleman from Pennsylvania is, for evenhandedness across the board in dealing with these problems.

Mr. HASH. We are, too, Mr. Chairman. I would just like to say that we join you in every bit of concern that you expressed on behalf of the beneficiaries and their out-of-pocket expenses associated with outpatient payments. I would say that all of us who have been involved in public policy, in public life, both the administration and the Congress, on all sides, share a responsibility for not addressing this problem earlier.

Chairman THOMAS. Thank you for that statement. Thank you. Basically what you are saying is that what you have written is not necessarily what you mean, because sometimes there was a failure to go into the detail and sometimes too much detail. I understand that.

The gentleman from California wants to make a point.

Mr. STARK. Mr. Chairman, I would like to say, directed to you and Mike, that it was brought to my attention that we only have a growth of $5 billion that we can spend without triggering, under pay-go, a sequester. The limit is $2.78 billion in 2000, and it drops $1 billion to $37,000,000.

It is my further understanding that the first one to get in under the wire, will not be sequestered. If we got down to the White House with $5 million in paybacks, then, subsequently, the Defense Department came in later, ours stays in; their's goes out. I am just wondering if Mike's department has been in touch with CBO on this, or, I am sorry, OMB, whose numbers prevail in this instance?

It seems to me we may be living here in a bit of a paradise which may not exist, unless the Chair knows some way out of that one. If we are sitting here, as we are sitting, if the Committee on Agriculture is up there spending an extra $5 billion we are not looking for and they get to the White House first, we may be out of luck entirely.

I just would ask either the chairman or Mr. Hash if they are familiar with this procedural roadblock we may be facing?

Chairman THOMAS. Would the administration like to respond in terms of where they place Medicare beneficiaries vis-à-vis other programs?

Mr. HASH. We place them right where you do, Mr. Chairman, right at the forefront of our priority.

I am not familiar with these numbers. I apologize, Mr. Stark. But I would be happy to follow up with a discussion about the implications of this. I am not prepared to at this point.

Chairman THOMAS. The Chair made an initial statement about the question of income security and the reconciliation plan that has been passed by the Congress, especially section 202, which refers to both Social Security and Medicare as part of that retirement security.

There are accounting terms that are referred to, like FIFO, first in, first out, or LIFO, last in, first out. I think those are not appropriate in dealing with the problems that we face, where we identify needs. This chairman is much more concerned with the administration's willingness to carry on a shared responsibility.

The gentleman mentioned a dollar amount. If the administration is willing to carry 50 cents on the dollar of that amount, we will carry 50 cents on the dollar, and combined, it could be a reasonable and appropriate adjustment. It is going to be difficult for the Congress to carry 100 cents on the dollar for a number of changes, especially where we believe the administration can make adjustments that would assist significantly in the total dollar amounts that needed to be found.

This chairman is not operating on any timeline or felt need to beat somebody somewhere. The needs are going to be examined. The needs are going to be assessed and the needs are going to be taken care of, and I have full confidence that whatever dollar amount we find will be covered in whatever way it needs to be covered.

Mr. MCDERMOTT. Mr. Chairman, may I ask one short question?

Chairman THOMAS. Yeah.

Mr. MCDERMOTT. A yes or no question.

Chairman THOMAS. Yes or no question, oh, I love those. Go ahead.

Mr. MCDERMOTT. Have you been consulted on any legislation to be presented to the Congress in this session at this point?

Mr. HASH. Consulted by Members of Congress?

Mr. MCDERMOTT. By this committee.

Mr. HASH. We have been working with the staffs, staffs on both sides of the aisle, with regard to——.

Mr. MCDERMOTT. But have you seen language is what I am talking about?

Mr. HASH. I have not seen language yet.

Mr. MCDERMOTT. OK. Thank you.

Chairman THOMAS. Thank you, Administrator.

Mr. HASH. Thank you, Mr. Chairman.

Chairman THOMAS. Now if the folks the buck has been passed to would come forward. The chair of the Medicare Payment Advisory Commission. At least this time she appears before us in that capacity, Dr. Wilensky, and our friend from the General Accounting Office, the Director of the Health Financing and Public Health Issues area, Dr. Bill Scanlon.

As is usually the case, any written testimony you have will be made a part of the record. You can address us in any way you see fit orally during the period that you have, and Gail, we will begin with you and then move to Bill. Thank you for being with us.

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION AND FORMER ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Ms. WILENSKY. Thank you, Mr. Chairman and Members of the Committee. I am pleased to be here to talk about potential reasons to the Balanced Budget Act. I am here as chair of MedPAC, representing the Medicare Payment Advisory Commission.

I want to spend the few minutes I have to talk about what we know and what we don't know, as of yet, about what has happened as a result of the Balanced Budget Act, both to the providers of services to seniors and to some of the health care plans. I would like to review some of the recommendations that MedPAC has made and also some of the options that you may want to consider as you go forward.

As you know and as you heard again from Mike Hash, the actual spending under Medicare has been growing at a slower rate than was anticipated, substantially slower. There are at least three reasons for the slowdown.

He mentioned the one that is probably the most important, that is, fraud and abuse. CBO has estimated as much as half of the slowdown has been because of behavior changes in billing as a response to very aggressive actions by the Inspector General and the Department of Justice on fraud and abuse. A second reason is the "deer in the headlights" phenomenon. We have seen this before, when DRGs were put in place in the eighties, where for the first year or two hospital spending slowed dramatically, they didn't replace people who had left, slowed down capital expenditures, etc. The slow down from this was probably temporary, and some of the slower processing of bills is also temporary, unlike the fraud and abuse response which may well persist.

Having acknowledged the slowdown, we really don't know very much about what the slowdown has meant in the sense of what changes are from Medicare as opposed to changes that are coming from the rest of health care, such as aggressive pressure from managed care and other types of health care plans. You know we are frustrated by our lack of data. You may or may not know that HCFA and MedPAC are working together to try to resurrect something like the hospital panel data so that when we report to you in March, we will not only have the 1998 cost reports, but we will have some snapshot data that will be much more current. It won't be perfect but we are tired of saying we are only looking at 1997 data and are trying to actually do something about that.

Let me mention home care. This is an area that has come up in a number of discussions. What we know is that homecare is an area where we saw very rapid growth for 10 years, from 1986 to 1996. Since then, the spending has slowed down substantial. Some homecare agencies have closed. Fewer people are receiving services, but we really don't know very much about what these changes mean. This is because the data is unadequate and the guidelines for coverage are not very clear; all we can really say is that spending is somewhat slower than it was after a period of very rapid growth. I will come back to this in a minute.

MedPAC is also concerned about the plan withdrawals from Medicare+Choice. This is a complicated area. The plans have raised

some concerns about changes in regulations, the uncertainty about dealing with government as a business partner, the potential for yet more changes, as indicated by the President's proposal in June, which would completely revamp once again how at-risk plans would interact with the Government. They are also concerned about risk adjustment.

The question now is what kind of changes to the BBA might make some sense. Let me offer some suggestions. There are three that I would put at the top of my list. In discussions with other commissioners, there seem to be widespread agreement that these three are the most important.

The first concerns nursing homes. There is widespread belief that the payments for the sickest patients under the current medical classification system is too little. One of the members commented that there hasn't been an increase in nursing home admissions in the discussion about home care. I would say that this shouldn't necessarily be regarded as a good sign. The fact that there has not been increases in nursing home admissions or in the time that people are in nursing homes may suggest they are not getting pushed out of home care and into nursing homes, but it may also be reflective of problems in nursing homes. This is an area I would put high on my list, if you are going to make any change at all.

A second area concerns about outpatient therapy caps. You have already heard about this. Let me remind the committee that there was a problem you were trying to fix. There was a concern that this was an abusive area in Medicare. The problem, as I see it, is that there is no relationship between the cap and the clinical indicators of the patient. This is what you ought to try to fix. To just dismiss the notion of a cap would be too extreme. It would be better to try to moderate how the therapy cap is implemented. Having the cap only effective for Part B covered people who are in nursing homes, after their Medicare coverage of a hundred days, is to hit the most vulnerable who have no other place to seek therapy option. This needs to be changed.

The third are concerns about outpatient prospective payment. Payment to the outpatient part of hospitals was reduced in 1998. If the prospective payment system goes forward as now is scheduled in July, there will be a further reduction of some 5.7 percent. There is also no phase-in, to its implementation. MedPAC is also concerned about the aggregated nature of the classes that HCFA has proposed. Our recommendation is to reduce the hit on payments, if possible, and phase-in the prospective payment system. Phasing in is almost always our recommendation. As I've said, we are concerned that the classes are too large, which means HCFA will overpay some procedures or visits and you underpay others. That is an invitation to bad activities.

There are a couple of other areas that we think should be changed if you can also accommodate these changes. The physician community has been concerned that there is no adjustment for projection errors in the calculation of the sustainable growth rate. That means any errors accumulate over time. We recommended in our 1999 report that this be changed. We have also been concerned that the GDP plus zero growth rate is quite low and have suggested that it be increased slightly to accommodate scientific ad-

vances. This is something you have heard from us in the past as well.

And while I strongly support the notion of risk-adjusting plans, the rate at which you phase-in risk adjustment can be debated. HCFA picked 5 years. That was arbitrary. MedPAC has been concerned that the risk-adjustment strategy only relies on inpatient data. If a plan has expenses that keeps seniors out of the hospital, like some of the disease management activities, this increases plan expenses in the current year and then the plan gets reduced payment if seniors are kept out of the hospital because of actions the plans have undertaken. HCFA has indicated they will try to respond to this problem but as yet I haven't heard any response about what they are planning to do.

Once again, let me say that partial capitation which blends fee for service and a capitation payment, might be an answer. It might reduce the plans' uneasiness that if they get some sicker patients, than is demonstrated by our very imperfect risk-adjustment mechanism, that they wouldn't get hit so hard. Partial capitation also encourages them not to skimp on services.

In sum, I think there is a rationale for making some adjustments to the BBA. The first three I mentioned are the ones that are most compelling, but there are some others as well, depending on how much additional funding you think is appropriate. Thank you.

[The prepared statement follows:]

Statement of Hon. Gail R. Wilensky, Ph.D., Chair, Medicare Payment Advisory Commission, and former Administrator, Health Care Financing Administration

Good morning Chairman Thomas, Congressman Stark, members of the Committee. I am Gail Wilensky, chair of the Medicare Payment Advisory Commission (MedPAC), and I am pleased to participate in this hearing looking at refinements to the Medicare provisions in the Balanced Budget Act (BBA) of 1997. My testimony describes what we know and do not yet know about the implications of the BBA for Medicare beneficiaries, health care providers, and Medicare+Choice plans. I will also discuss recommendations that MedPAC has made this year and other options you may wish to consider.

The changes enacted in the BBA and implemented by the Health Care Financing Administration (HCFA) reduced Medicare payment rates relative to what they would have been otherwise for most providers and for Medicare+Choice plans in many areas. Not surprisingly, these changes have generated concerns among providers and health plans about their effects. Providers' and plans' concerns frequently have been heightened by their perception that the effects have been more harsh than the Congress intended, or that the effects, while intended, have nonetheless imposed burdens, and that there are specific problems with how HCFA has implemented the law.

SUMMARY

A greater than expected slowdown in Medicare spending began in fiscal year (FY) 1998 and has continued this year. Medicare spending rose only 1.5 percent last year, compared with a projection of 5.7 percent by the Congressional Budget Office when BBA was enacted. Through the first 11 months of FY 1999, outlays ran about 1 percent below the FY 1998 rate for the same period.

Unfortunately, we cannot draw definitive conclusions about what the slowdown in spending means. Almost two years have gone by since the first BBA policies were put in place, but systematic data for this period are still extremely limited. Moreover, we cannot easily isolate the effects of the BBA from other changes in policy or market conditions. For example:

• Hospitals have argued that the changes in Medicare payments are reducing their margins and impinging on their ability to provide quality care. But the most recent complete information we have for the Medicare program is from FY 1997, the year before the BBA took effect.

• For home health services, we have seen lower than expected outlays, closures of home health agencies, and declines in the use of services. But our interpretation of these findings is clouded by other policy changes, notably efforts by HCFA and the Department of Justice to cut down fraud and abuse and by the lack of clear eligibility and coverage guidelines for home health care.

• Widely publicized withdrawals of plans from the Medicare+Choice program suggest that the program is not achieving the goals its authors intended. But managed care enrollment has continued to grow—albeit at a slower rate—since the BBA was enacted. Moreover, the pattern of withdrawals suggests that factors in addition to Medicare's payment rates are playing a role.

The BBA had ambitious objectives. For Medicare's fee-for-service program, it aimed to modernize payment systems and slow the growth in spending, while preserving Medicare beneficiaries' access to high-quality health care. For Medicare's managed care program, the BBA allowed new types of plans to participate and instituted new requirements intended to enable beneficiaries to choose more effectively among their health plan options. To expect legislation this sweeping to achieve all of its objectives flawlessly is unrealistic. In some cases, targeted changes in statute or regulation could improve Medicare's payments and access to care for beneficiaries. But the complaints of providers and health plans notwithstanding, we have no evidence that wholesale changes in the BBA are either necessary or desirable.

How did the BBA change payments to providers?

The BBA enacted the most far-reaching changes to the Medicare program since its inception. The law reduced payment updates or otherwise slowed the growth in payments to virtually all fee-for-service providers. The law established, or directed to be established, new prospective payment systems for services provided by hospital outpatient departments, skilled nursing facilities, and home health agencies, and it revised the mechanism for updating fees for physician services. Finally, the BBA changed the way base payment rates are determined for health plans participating in the Medicare+Choice program and directed HCFA to implement a new system of risk adjustment that accounts for beneficiaries' health status.

Inpatient hospital services

The BBA changed payments for inpatient hospital services in a number of ways. For hospitals under Medicare's prospective payment system (PPS), the law provided for no update to operating payments in FY 1998 and limited updates from FY 1999 through FY 2002. It required phased reductions in the per-case adjustments for the indirect costs of medical education (IME) and, temporarily, for hospitals serving a disproportionate share (DSH) of low-income patients. And it instituted a new transfer policy for 10 high-volume diagnosis related groups (DRGs), reducing the payment rates when hospitals discharge patients in these DRGs to post-acute care facilities following unusually short stays.

By themselves, lower updates would have slowed the growth in payment rates to hospitals for inpatient services but would not have reduced them. In FY 1998, however, the combined effect of the freeze on payment rates, smaller IME and DSH payment adjustments, and a small decline in the case mix index reduced payment rates in absolute terms. Payment rates should begin to increase again in FY 1999, albeit at a slower rate than would have occurred in the absence of the BBA.

Outpatient hospital services

In addition to changes in payments for inpatient services, the BBA also enacted major changes in Medicare's payments for services provided in hospital outpatient departments. It eliminated the so-called formula-driven overpayment under which Medicare's payments did not correctly account for beneficiaries' cost-sharing and extended the reduction in payments for services paid on a cost-related basis. The law also directed the Secretary to establish a prospective payment system for services that have been paid at least partially on the basis of incurred costs.

Hospitals have not yet felt the full impact of the BBA provisions affecting outpatient services. MedPAC estimates that elimination of the formula-driven overpayment, which took effect in 1998, reduced payments by about 8 percent. However, the PPS that was to have gone into effect in January 1999 will not be put in place before next summer. HCFA originally estimated that the PPS would reduce payment rates by 3.8 percent, on average, but has since revised its estimate of the reduction to 5.7 percent. These estimates likely overstate the ultimate reduction, however, as hospitals will have an incentive to code outpatient services more accurately than they do now.

Services in skilled nursing facilities

The BBA enacted a PPS for services provided in skilled nursing facilities (SNFs). These services had previously been paid on the basis of costs, subject to limits on routine services. Under the new system, payments are intended to cover the routine, ancillary, and capital costs incurred in treating a SNF patient, including most items and services for which payment was previously made under Part B of Medicare. Patients in SNFs are classified under the Resource Utilization Group system, version III (RUG-III), which groups patients by their clinical characteristics for determining per diem payments.

The new payment system slows spending growth for SNF services by moving these facilities from cost-based reimbursement to federal rates that are based on average allowable per diem costs in FY 1995, trended forward using the increase in the SNF market basket index less 1 percentage point. Because nursing home spending—particularly for ancillary services—grew rapidly between FY 1995 and FY 1997, using FY 1995 as the base for payment purposes reduced payments for many nursing homes. The PPS is being phased in over a four-year period that began in 1998. Payments in FY 1999 are based on a 50/50 blend of federal rates and facility-specific rates and will be based entirely on the federal rates beginning in FY 2001.

Home health services

Before the BBA, home health agencies were paid on the basis of costs, subject to limits based on costs per visit. The BBA directed the Secretary to implement a prospective payment system effective October 1999—since delayed by the Congress to October 2000—and established an interim payment system (IPS) intended to control the growth in spending until the PPS was in place. The IPS reduced the limits based on costs per visit and introduced agency-specific limits on average costs per beneficiary based on a blend of agency-specific costs and average per-patient costs for agencies in the same region. Home health agencies are now paid the lower of their actual costs, the aggregate per-beneficiary limit, and the aggregate per-visit limit. Agencies' per-beneficiary limits are based on their average costs per beneficiary in FY 1994, trended forward using the home health market basket index. As with nursing homes, home health spending grew rapidly in the mid-1990s. For this reason, using FY 1994 as a base for payment led to substantial payment cuts for some home health agencies.

Physician services

The BBA replaced the volume performance standard system that had been used to update physicians' fees with a new sustainable growth rate (SGR) system. It also introduced a single conversion factor for all physician services that reduced payments for some services while increasing them for others. Finally, the BBA established requirements for payments to physicians for their practice costs.

Unlike some of the other provisions of the BBA, changes to Medicare's payments to physicians occurred almost immediately. Starting on January 1, 1998, the single conversion factor was implemented along with the first step toward revising practice cost payments. The effects of these changes were largest for some surgical procedures, such as cataract surgery and some orthopedic procedures, where payment rates fell by 13 percent or more. Payment rates for other services went up, however. Payments for office visits and some diagnostic services increased by at least 7 percent.

Medicare+Choice plans

Before enactment of the BBA, Medicare's payments to private health plans participating in the section 1876 risk contracting program were based on the average payments made on behalf of beneficiaries in its traditional fee-for-service program living in the same county. The BBA severed the link between county-level trends in fee-for-service spending and payment updates to plans by instituting a floor under county payment rates, blending local and national payment rates (subject to a so-called budget-neutrality provision), and removing the component of base rates attributable to spending for graduate medical education. Overall, the law limited updates to payment rates in all counties by slowing the rate of growth in national fee-for-service spending and by subtracting a specified factor from that rate. The blending policy raised updates in some counties but reduced updates in others.

In addition to changes in base payment rates, the BBA required HCFA to implement a new system of risk adjustment that takes into account the health status of the beneficiaries that plans enroll. The law laid out a very tight time schedule, requiring HCFA to implement the new system by January 1, 2000. The system that HCFA has proposed will raise payments for certain enrollees who were hospitalized

in the year preceding the payment year and will reduce payments for other enrollees. The amount of the higher payments will depend on the principal diagnoses associated with hospital admissions. HCFA has proposed to phase in the new system over a five-year period and has estimated that other things being equal, the new system would reduce payment rates by 7.6 percent on average at the end of the phase-in.

What has been the impact of these payment changes?

Providers' and plans' concerns are clearly relevant to any assessment of the BBA. But at the same time, we must remember that the primary objective of the Medicare program is to maintain access to high-quality care for beneficiaries. Assessing the implications of the BBA should therefore focus on whether access to or quality of care has been hampered and, if so, what can be done about it.

In evaluating the potential impact of the BBA on access and quality, two issues seem especially important. One is how policies may interact to affect providers' ability and incentives to furnish care. Hospitals, for example, often furnish many types of services and must therefore face the combined effects of policy changes that have altered payments for virtually every service they provide. Medicare+Choice plans face changes in the way base payment rates are calculated, new requirements for participation, and future changes in payments arising from the introduction of a new risk adjustment system.

A second issue is whether the new payment systems adequately reflect predictable differences in patient care costs. Industry and other analysts have raised this issue with regard to the IPS for home health agencies and the prospective payment systems being developed for outpatient hospital services and being phased in for SNFs. Where predictable differences in costs are not taken into account, financial incentives are created for providers to deny access to care or under treat identifiable groups of patients.

Sorting out the effects of multiple changes in payment policies and the introduction of new payment systems on beneficiaries' ability to obtain the medical services they need is challenging in two important respects. First, many BBA changes have not yet been fully phased in, and data to evaluate the impact of recent changes are in many cases not yet available. Second, measuring access to care is difficult. Because directly measuring appropriate beneficiary use of services is hard to do with existing data, policymakers often look at determinants of access, such as provider availability and willingness to serve Medicare beneficiaries, as well as the nature and extent of other barriers to access that beneficiaries face. Interpreting the findings of these analyzes can be difficult, however, because we cannot isolate the effects of changes in Medicare policy from the effects of other changes in health care financing or delivery arrangements.

Financial impacts

During the past year, various indicators have been cited as measuring the financial impact that the BBA is having on providers. The hospital industry, for example, has issued several reports analyzing the impact of the BBA on hospital revenues and margins. A second example is the closures of home health agencies since the IPS was put in place. The home health industry and its observers claim that the IPS caused declines in the number of agencies, putting beneficiaries' access to home health care services at risk.

Hospitals. The reports issued by the hospital industry contain new projections, but they do not present new data. In response to congressional requests, MedPAC staff has analyzed these projections and found that all of them portray a more adverse impact of the BBA than we believe to be the case. Some present a particularly inaccurate picture of the impact in FY 1998 by assuming a rate of increase in costs that substantially exceeds what we already know to have occurred. Data from the American Hospital Association's National Hospital Panel Survey suggest that when complete Medicare cost report data become available later this year, we will again see a decline in Medicare cost per discharge for FY 1998, the fifth year in succession.

Although we believe that industry reports somewhat overstate the impact of the BBA on hospital margins, they do correctly present its overall direction. As it was intended to do, the law has reversed a six-year trend of Medicare payments rising more rapidly than the costs of treating Medicare beneficiaries. Still, two reasons make it difficult to interpret what changes in total margins mean for Medicare policy. First, the financial pressure that hospitals are currently experiencing reflects both changes in Medicare's payment policies and continued strong downward pressure on revenues from private managed care plans and other payers. In FY 1997, private payers' payments dropped by 4 percentage points relative to the cost of

treating their patients, while Medicare payments rose relative to costs. Data for FY 1998 are not yet available, but we have every reason to believe that the downward pressure from private payers continued as Medicare reduced its payments. Second, because hospitals can be expected to continue responding to financial pressures by slowing cost growth—the overall increase in costs per case for all patients has been below 2.5 percent for five straight years—projected margins serve only as a gauge of financial pressure, not as a prediction of what will occur. MedPAC has seen no convincing evidence that the changes to date have affected either quality or access in the inpatient sector, but we will continue to monitor developments.

Home health agencies. To examine whether the closures of home health agencies may have affected beneficiaries' access to services, the General Accounting Office (GAO) analyzed the distribution of closures across urban and rural counties. The agency also interviewed stakeholders—representatives of state agencies, beneficiary advocates, hospital discharge planners, and managers of home health agencies—in 34 primarily rural counties that had experienced significant agency closures or declines in the use of services. GAO concluded that the closures have had little impact on Medicare beneficiaries to date. However, the agency noted that beneficiaries who are more costly than average may face difficulty in obtaining home health care in the future as agencies change their behavior in response to the IPS.

The GAO study found that while about 14 percent of agencies had closed between October 1, 1997, and January 1, 1999, more home health agencies were in existence at the beginning of FY 1999 than at the beginning of FY 1996. The study found that most of the closures occurred in urban counties and that about 40 percent of the closures occurred in three states—Louisiana, Oklahoma, and Texas—that had seen a large expansion in the number of agencies and that had utilization rates well above the national average.

Stakeholders interviewed by the GAO reported few access problems currently. State survey agency representatives, for example, indicated that adequate capacity continued to exist despite the closures and reported that they had received few complaints about access to Medicare home health care. Discharge planners and home health agency managers reported that beneficiaries living in counties that had lost agencies still had adequate access through agencies located in adjacent counties.

Willingness to serve beneficiaries

Industry and policy analysts have expressed concerns about the case-mix adjuster used in the new PPS for SNFs, the lack of case-mix adjustment in the IPS for home health agencies, and about the new system for determining physicians' fees. In the Medicare+Choice program, questions center around whether the lack of participation by new plans and withdrawals by existing plans reflect payment levels or other factors.

Skilled nursing facilities. In the case of SNFs, concerns have centered around the payment weights used in conjunction with the RUG-III system. Although SNF patients can vary significantly in their use of ancillary services and supplies such drugs and biologicals, payments for patients in different RUG-III categories are based on estimates of the time providers's staff spent furnishing nursing and therapy services. SNFs may be unwilling to serve patients in some high-acuity RUG-III groups for whom the costs of services may exceed the payment rates.

The Office of the Inspector General (OIG) of the Department of Health and Human Services has undertaken a study to assess these concerns. The OIG surveyed a random sample of 200 hospital discharge planners responsible for arranging nursing home care for patients being discharged from hospitals.

The OIG report concluded that while serious problems in placing Medicare beneficiaries in nursing homes are not apparent, SNFs are changing their admitting practices in response to the new payment system. Two-thirds of discharge planners responding to the survey reported no difficulty in placing Medicare patients. At the same time, almost half of the discharge planners surveyed reported that nursing homes have begun requesting more detailed clinical information about patients and more often assessing patients directly before making admissions decisions.

The survey found that some patients have become harder to place, including those who need extensive services, such as intravenous feedings or medications, tracheostomy care, or ventilator and respirator care. These findings are consistent with concerns that payment weights under the PPS do not account adequately for certain medically complex patients.

Home health agencies. The IPS for home health agencies has been criticized because the aggregate per-beneficiary limit is based on historical patterns of use and does not account for changes in agencies' patient mix. Industry and beneficiary representatives have asserted that this limitation has made home health agencies unwilling to accept patients who are likely to need extensive services. To assess these

concerns, MedPAC contracted with Abt Associates, Inc., to survey about 1,000 home health agencies in early 1999 on their experience under the IPS. We also convened a panel of experts familiar with beneficiaries' problems accessing home health services.

The results of our survey of home health agencies are consistent with the preliminary information we have on utilization. The agencies we surveyed generally reported that their Medicare caseloads have fallen and that the number of visits per user they provide has decreased. Almost half reported that they had changed the mix of services they provide, with fewer aide visits being the most common response. While virtually all of the agencies we surveyed reported that they are accepting new patients, the share accepting all new Medicare patients was 75 percent, compared with 85 percent before the IPS was implemented. About 40 percent of agencies reported a change in admissions practices—refusing to admit patients that they would have accepted before the IPS—and 30 percent reported discharging patients because of the IPS. Agencies most frequently identified long-term or chronic care patients as those they no longer admitted or have discharged.

These findings are consistent with the claim that the IPS has hampered access, but they do not tell the whole story because the change in payment policy occurred at the same time HCFA was implementing other policies intended to reduce fraud and abuse, including stepping up oversight of home health care providers and imposing a four-month moratorium on the certification of new agencies in early 1998. The agency also adopted a new procedure for processing claims for home health care services. Assessing the effect on beneficiaries of changes in home health agencies' willingness to serve them is further confounded because we cannot determine whether the changes in use of home health services observed during the past two years are appropriate. Medicare's standards for eligibility for and coverage of home health services are to loosely defined for us to do so.

Physician services. Three aspects of the new mechanism for setting physicians' fees have raised questions regarding their impact on access. First, the introduction of a single conversion factor reduced payment rates for surgical services, while payment rates for primary care and other nonsurgical services generally increased. Second, the Secretary's lack of authority to correct for projection errors and the potential for oscillations in fee updates under the SGR system have raised questions about whether updates are appropriate. Because the SGR is cumulative, uncorrected projection errors affect all subsequent updates. This happened in 1999, when an unexpected slowdown in Medicare+Choice enrollment growth led to a smaller than projected decline in Part B fee-for-service enrollment. Third, the SGR system as currently designed has the potential for oscillation in fee updates because of problems with the data and methods used to calculate the updates. These problems are likely to lead to extreme positive and negative updates.

To assess the effects of the payment changes introduced in 1998, MedPAC contracted with Project HOPE to survey 1,300 physicians on their willingness to serve Medicare beneficiaries. The survey data were reassuring. Among physicians accepting all or some new patients, over 95 percent were accepting new Medicare fee-for-service patients both in 1997, before the new payment policy changes were implemented, and in early 1999. The survey also found that only about 10 percent of physicians reported changing the priority given to Medicare beneficiaries seeking an appointment. Of those, the percentage giving Medicare patients a higher priority was almost the same as the percentage giving Medicare patients a lower priority.

Medicare+Choice plans. The Congress intended the Medicare+Choice program to expand beneficiaries' health plan options, but this has not occurred. Plan participation has decreased from a year ago: of 347 contracts HCFA had with risk plans in 1998, 99 of those plans withdrew from serving at least one county, and many withdrew from the Medicare+Choice program altogether. This coming January, another 99 contracts will either be canceled or modified to reduce service areas. At the same time, however, enrollment in Medicare+Choice plans has continued to grow. Despite a brief dip in growth earlier this year, enrollment in these plans has grown by 6.5 percent (about 400,000 enrollees) since a year ago.

Payment levels are ultimately an important determinant of plan participation. However, payment levels alone do not yet appear to have had much impact either in encouraging new plans to enter the market, or inducing existing plans to leave. For example, despite the introduction of the floor and blend payments, we have not seen plan participation expand significantly in counties that benefitted from those provisions. Similarly, plan withdrawals have been disproportionately lower in counties where payment growth has been most constrained. Instead, plans' reluctance to participate may stem from concerns about regulatory issues and about the anticipated impact of risk adjustment on payments in coming years.

Where do we go from here?

Although there is no systematic evidence to date that beneficiaries' access to care has been impaired, the vast number of changes to Medicare payment policy introduced by the BBA make it more important than ever to monitor access. In our March and June reports to the Congress, MedPAC noted where we believe policy changes are not yet warranted and recommended specific targeted policies that could help to alleviate some of the concerns that have been raised regarding access to care in the future.

Hospital inpatient services

In our March report, MedPAC concluded that the operating update for FY 2000 enacted in BBA—1.8 percentage points less than the increase in HCFA's operating market basket index or 1.1 percent—will provide reasonable rates. In formulating our recommendation, MedPAC took into account part, but not all, of the cumulative reduction in costs per case that has occurred. We noted that hospitals have responded to an increasingly competitive market by improving their productivity and by shifting services to other sites of care. At the same time, we recognized factors pointing to the need for caution in specifying future updates, including emerging evidence that the decade-long trend in rising case mix complexity, which automatically increases PPS payments, may be subsiding. We also questioned whether the unusually low rate of hospital cost growth observed in recent years can be sustained without adverse effects on quality of care.

Hospital outpatient services

MedPAC has concerns about the PPS proposed by HCFA for hospital outpatient services. In basing payments on groups of services, instead of individual services, the system is likely to overpay for some services and underpay for others. This could lead to access problems in the future for beneficiaries needing services whose payments fall short of costs. In our March report, MedPAC recommended that the PPS be based on the costs of individual services. Since that recommendation was made, HCFA has been collecting comments on its PPS proposal, with the formal comment period ending July 30, 1999. HCFA will review the comments with the assistance of a private contractor, 3M Health Information Systems. HCFA then plans to issue a final regulation at least 90 days before the PPS is implemented.

Implementing the outpatient PPS will reduce payments for virtually all hospitals but could have much larger effects on specific types of hospitals. For example, based on HCFA's original estimates—which do not take into account improvements in coding that will lead to smaller reductions—small rural hospitals would see a 17 percent decline in payment rates, and cancer hospitals would see a drop of more than 30 percent. Given these changes, MedPAC recommended that the Secretary closely monitor the use of hospital outpatient services to ensure that beneficiaries' access to appropriate care is not compromised. Consideration should also be given to phasing in the new payment system to help us detect any problems before they become severe.

Skilled nursing facilities

The OIG report on the willingness of SNFs to continue accepting Medicare beneficiaries provides some comfort that early anecdotal reports of access problems do not indicate a widespread problem. Nonetheless, MedPAC remains concerned about the mismatch between payments and costs for patients who require relatively high levels of nontherapy ancillary services and supplies could hamper access in the future. In our March report, we recommended that the Secretary continue to refine the classification system to improve its ability to predict the use of nontherapy services and supplies. An improved classification system would match payments more closely to beneficiaries' needs for services and help to avoid access problems among medically complex patients. HCFA has indicated that it is researching the adequacy of payments under the PPS and will implement refinements next year if that research indicates changes are warranted.

Home health services

Implementing a PPS for home health care services that accounts for differences among beneficiaries will help to ensure access for those who require extensive care. MedPAC is concerned, however, that the timetable for implementing the PPS is very tight. Accordingly, we recommended in our June report that the Congress explore the feasibility of establishing a process for agencies to exclude a small share of their patients—say 2 percent—from the aggregate per beneficiary limits. Under our recommendation, Medicare would reimburse care for excluded patients based on the

lesser of actual costs or the aggregate per-visit limits. MedPAC believes that such a policy should be implemented in a budget-neutral manner.

In the longer run, ensuring that Medicare beneficiaries have access to appropriate home health care services will require clarifying the benefit. To that end, MedPAC recommended that the Secretary speed the development of regulations that would outline home health care coverage and eligibility criteria based on the clinical characteristics of beneficiaries and that she recommend to the Congress the legislation needed to implement those regulations.

Physician services

In part because of their technical nature, problems with the sustainable growth rate system that determines updates to payments for physicians' services have received less publicity than concerns about facility payments. But because uncorrected projection errors and wide swings in payment updates could raise access problems in the future, MedPAC recommends that the Congress require the Secretary to correct estimates used in SGR system calculations every year and that legislation be enacted to modulate swings in updates. Further, we recommend that the Congress revise the SGR to include an allowance for cost increases due to improvements in medical capabilities and advancements in scientific technology.

Medicare+Choice plans

In our March report, MedPAC recommended that the Secretary work with organizations offering plans to identify specific regulations or program policies for which changes, delays in implementation, or administrative flexibility could reduce the burden of compliance without compromising the objectives of the Medicare+Choice program. Two specific changes that we noted—moving back the deadline for filing adjusted community rate proposals and giving Medicare+Choice organizations the flexibility to tailor their benefit packages within their services—have already been done.

The Commission also made recommendations concerning HCFA's proposed system of risk adjustment. Although the interim risk adjustment proposal has important shortcomings, we believe it represents a substantial improvement over the current method and that its benefits outweigh its costs. We support phasing in the new system because doing so will avoid large abrupt changes in payments to Medicare+Choice organizations and will give policymakers time to monitor and evaluate the interim system's effects on organizations and beneficiaries. Given its limitations, the interim risk adjustment method should be replaced as soon as possible by a comprehensive method based on enrollees' encounters in all settings, not just inpatient.

Chairman THOMAS. Thank you, Gail. Go.

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. SCANLON. Thank you very much, Mr. Chairman and Members of the Subcommittee. I am pleased to be here today as you discuss the issues that have arisen with respect to the program changes that were mandated by the Balanced Budget Act. As has been very clear from today's discussions, the BBA set into motion significant changes that both attempted to modernize Medicare payment methods and rein in spending.

We have undertaken several studies to review BBA impacts on different types of services at the request of both this Subcommittee and others, and I will focus my remarks today on changes that have affected home health agencies, skilled nursing facilities, as well as Medicare+Choice plans. My written statement also describes changes affecting outpatient therapy services.

Concerns by the industries involved have been raised about BBA's impacts on beneficiary access and on the financial viability of providers. The question is how valid are those concerns. The BBA made necessary and fundamental changes to Medicare's payment methods to slow spending growth while protecting appropriate beneficiary care. Prior to the Balanced Budget Act, spending on post-acute services, especially home health and skilled nursing facility care, was growing very rapidly. No analyses supported why the growth should be so high, and there was significant concerns that overutilization, inefficient delivery, and fraud and abuse played roles.

Similarly, enrollment in Medicare managed care plans has been increasing significantly, but extensive research demonstrated that rather than saving money this enrollment actually cost the program more due to the poor risk adjustment of rates.

While refinements are required to make the BBA payment systems more effective, their design intentionally makes inefficient providers change their practices to remain in the Medicare business. For Medicare managed care enrollees, BBA can also mean that enrollees may not be able to receive as many additional benefits—ones that are not offered by the traditional program—without paying premiums. Some may also not have access to a Medicare+Choice plan at all. Yet for others, joining a Medicare+Choice plan may still remain the beneficiary's best option for a broadened benefit package at an affordable price.

The impacts of payment reform have been very noticeable. In the case of home health, we reported in May that the number of Medicare certified agencies had declined by 14 percent. A significant number of additional agencies have stopped participating since then, but because the number of agencies had virtually doubled between 1990 and 1997, beneficiaries are still served by more than 8,000 agencies.

Home health use has also dropped, but the decline does not appear to be related to agency closures. It is consistent, however, with interim payment system incentives to control the volume of services provided to beneficiaries and to narrow the widely divergent and unexplained variation in use. While access does not seem to be generally impaired, there are indications that beneficiaries likely to be costlier than the average may have more difficulty than before in obtaining home health services. The revenue caps imposed by the interim payment system are not adjusted to reflect variations in patient needs, a problem that should be ameliorated with the implementation of the prospective payment system. The challenges, though, of designing a home health prospective payment system are significant enough that we should be prepared to have to make refinements after we have implemented it.

Turning to skilled nursing facilities, several factors might suggest that the prospective payment system's impact on the viability of skilled nursing facilities would be less severe than is being claimed by providers. Medicare is a small portion of most skilled nursing facilities' business, and furthermore, only one-quarter of Medicare's current reimbursement for most facilities is based on prospective payment. The remainder reflects the facility's own his-

torical spending, spending that may be inflated due to the provision of excessive ancillary services in the past.

Nevertheless, recently one of the largest nursing home chains filed for Chapter 11 bankruptcy protection. We have been reviewing the difficulties of Vencor and other nursing home chains for the Senate Finance and Aging Committees. It appears that these companies' difficulties likely relate to much more than the Medicare prospective payment system.

Overall, the SNF prospective rates may have been set too high on average and thus, over rather than under-compensate providers. Nevertheless, it seems certain that modifications to the prospective payment system are necessary to more appropriately target payments to patients who require costly care. As Dr. Wilensky indicated, the payments for the high acuity patients are potentially not covering the cost of serving such individuals. The access problems, though, that result from that underpaying for these high cost cases, at least for the short term, are likely to lead to some beneficiaries staying longer in acute care hospitals rather than necessarily foregoing care. HCFA, as you have heard, is aware of the situation and is working to address this problem.

HMO withdrawals from the Medicare+Choice program have also attracted considerable attention, and approximately 100 plans last year and again this year either withdrew completely or reduced their service areas. Our report on last year's withdrawals and preliminary analysis of this year's indicate they were not driven by Medicare rates alone. Market share, enrollment, tenure in an area, and competition from other plans also played significant roles. Some sound business decisions made when Medicare was paying too much likely became problematic when payments were reduced.

Plans are also reducing the additional benefits they offer and instituting or increasing premiums. As I noted earlier, Medicare+Choice though still may be the best option available for beneficiaries that want to augment the benefits available in a traditional package.

We believe, in aggregate, Medicare+Choice rates remain sufficient. Last year on average, plans had to supply $54 per member per month in additional benefits because program payments exceeded the cost of their delivery in the Medicare payment benefit package. However, we are concerned that those resources are not necessarily targeted appropriately. Some plans may be underpaid even though average payments are more than adequate. Assuring that both the base rates and the risk adjustment process appropriately target funds is the critical challenge.

In conclusion, I would note that the BBA made the necessary and fundamental changes to Medicare payment methods for many providers in order to slow payment growth while preserving appropriate beneficiary care. It is clear we now need refinements to make these systems more effective. It is important that we also, though, recognize as Dr. Wilensky indicated, that we all, GAO, MedPAC and HCFA, are struggling with limited information on the full impact of these changes and, therefore, how best to refine them is more difficult. We need to undertake a thorough and fair analysis and have a fair trial of these provisions over reasonable periods before we engage in fundamental modifications.

Thank you very much, Mr. Chairman. I will be happy to answer any questions you or members of the committee may have.

[The prepared statement follows:]

Statement of William J. Scanlon, Ph.D., Director, Health Financing and Public Health Issues, Health, Education, and Human Services Division, U.S. General Accounting Office

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today as you discuss the effects of the Balanced Budget Act of 1997 (BBA) on the Medicare program. BBA set into motion significant program changes to both modernize Medicare and rein in spending. The act's constraints on providers' fees, increases in beneficiary payments, and structural reforms together were projected to lower Medicare spending by $386 billion over the next 10 years. Although some BBA provisions are in effect, data relevant to their impact are generally limited to date; other provisions have not yet been fully phased in. As a result, the act's full effects on providers, beneficiaries, and taxpayers will remain unknown for some time.

BBA's Medicare provisions were enacted in response to rapid program spending growth that was neither sustainable nor readily linked to demonstrated changes in beneficiary needs. The act's payment reforms represented bold steps to control Medicare spending by changing the financial incentives inherent in payment methods that, prior to BBA, did not reward providers for delivering care efficiently. To date, the Congress has remained steadfast in the face of intense pressure to roll back certain BBA payment reforms while waiting for evidence that demonstrates the need for modifications. Calls for BBA changes come at a time when federal budget surpluses and lower-than-expected growth in Medicare outlays could make it easier to accommodate higher Medicare payments. However, as the Comptroller General cautioned last week, the surpluses are merely projections that could fall short of expectations, and the imperative remains to find the reforms that will make Medicare sustainable and affordable for the longer term.[1]

My comments today focus on payment reforms affecting certain providers in Medicare's traditional fee-for-service program and providers in Medicare's managed care program. Specifically, I will discuss the effects on three providers of post-acute care services—home health agencies (HHA), skilled nursing facilities (SNF), and providers of outpatient rehabilitation therapy—and on the health plans participating in the Medicare+Choice program.

In brief, some providers of post-acute care and health plans in the Medicare+Choice program may have to rethink their business strategies as a result of BBA payment reforms, which seek to make Medicare a more efficient and prudent purchaser. Imperfections in the design of BBA-mandated payment systems require attention, and better information can help policymakers distinguish between desirable and undesirable consequences. Based on such knowledge, refinements can help ensure that payments are not only adequate in the aggregate but are also fairly targeted to protect individual beneficiaries and providers. Our issued and ongoing studies of various payment methods are instructive in this regard, and a summary of our results to date follows.

- *Home health care:* Our work indicates that (1) the reductions in the number of HHAs and changes in utilization were consistent with the objectives of the interim payment system to control the rapid growth that had preceded BBA and (2) appropriate access to Medicare's home health benefit has not been impaired. However, the prospective payment system (PPS) is a more appropriate tool for the long term than the interim payment system, because it is intended to adjust payments for differences in beneficiary needs. As we examine the challenges of designing a PPS, we are finding that that the PPS will likely require further adjustments after it is implemented as more information on home health costs, utilization, and users becomes available.
- *SNF care:* A PPS was implemented beginning in July 1998 with a 3-year transition to fully prospective rates, giving providers time to adjust to the new system. Our ongoing work suggests that factors in addition to the PPS have contributed to fiscal difficulties for some corporations operating SNFs. Nevertheless, certain modifications to the PPS may be appropriate to ensure that payments are targeted to patients who require more costly care. The potential access problems that may result if Medicare underpays for high-cost cases could lead to beneficiaries' staying in acute care hospitals longer, rather than foregoing care altogether. HCFA is aware of this potential targeting problem and is working to develop a solution.

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[1] *Medicare Reform: Ensuring Fiscal Sustainability While Modernizing the Program Will Be Challenging* (GAO/T-HEHS/AIMD–99–294, Sept. 22, 1999).

• *Caps on coverage of outpatient rehabilitation therapy:* In 1999, BBA established an annual $1,500 per-beneficiary cap on payments for outpatient physical therapy and speech/language pathology services combined and a separate $1,500 cap on outpatient occupational therapy. The caps reflect a legitimate need to constrain service use. For the vast majority of outpatient therapy users, the caps are unlikely to curtail access to services. Only a small share of beneficiaries receiving therapy services are high users. Further, most outpatient therapy users will likely have access to hospital outpatient departments, which are not subject to the $1,500 caps. In addition, owing to HCFA's partial approach to enforcing the caps, noninstitutionalized beneficiaries can avoid having the caps curtail service coverage by switching providers. Whether the caps restrict coverage for a small share of nursing home residents is less straightforward. A need-based payment system could help better target payments toward beneficiaries who genuinely require more services than allowed under the current dollar limits.

• *Payments to Medicare+Choice health plans:* Several BBA provisions address the long-recognized problem of excess payments to Medicare+Choice plans. Some provisions have begun to be phased in, such as reducing the annual rate updates; others have not yet become effective, such as the use of a risk adjustment method based on beneficiary health status. The net effect of the implemented revisions has been modest and, on average, has likely removed only a portion of excess payments built into the base rates. Moreover, the recent and upcoming rounds of plan withdrawals from Medicare are not, as the industry has argued, fully attributable to Medicare's lowered payment rates. The evidence emerging from recent rounds of withdrawals suggests that market share, enrollment size, and competition from other health plans factor into a plan's decision to participate in Medicare. Critical to making Medicare+Choice payment modifications are the establishment of an appropriate base rate and of a risk adjustment method that pays more for serving beneficiaries with serious health problems and less for serving relatively healthy individuals.

Background

The Medicare program consists of two parts: "hospital insurance," or part A, which covers inpatient hospital, skilled nursing facility, hospice, and certain home health care services; and "supplementary medical insurance," or part B, which covers physician and outpatient hospital services, outpatient rehabilitation services, home health services under certain conditions, diagnostic tests, and ambulance and other health services and supplies.

Growth in Medicare Spending for Home Health Care

During much of the 1990s, home health care was one of Medicare's fastest growing benefits; between 1990 and 1997, Medicare spending for home health care rose at an annual rate of 25.2 percent. Several factors accounted for this spending growth, most notably the relaxation of coverage guidelines. In response to a 1988 court case, a change in the coverage guidelines essentially transformed the benefit from one that focused on patients needing short-term care after hospitalization to one that also serves chronic, long-term-care patients.[2] The loosening of coverage and eligibility criteria contributed to an increase in the number of beneficiaries receiving services and the volume of services they received. Associated with this rise in utilization was an almost doubling in the number of Medicare-certified HHAs to 10,524 by 1997.

Also contributing to the historical rise in home health care spending were a payment system that provided few incentives to control how many visits beneficiaries received and lax Medicare oversight of claims. As we noted in a previous report, even when controlling for diagnoses, substantial geographic variation existed in the provision of home health care, with little evidence that the differences were warranted by patient care needs.[3] Additional evidence indicates that at least some of the high use and the large variation in practice represented inappropriate billings and unnecessary care.[4] Medicare oversight declined at the same time that spending mounted, contributing to the likelihood that inappropriate claims would be paid. To

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[2] *Duggan v. Bowen,* 691 F. Supp. 1487 (D.D.C. 1988).

[3] *Medicare: Home Health Utilization Expands While Program Controls Deteriorate* (GAO/HEHS–96–16, Mar. 27, 1996).

[4] *Medicare: Improper Activities by Mid-Delta Home Health* (GAO/T-OSI–98–6) and Office of the Inspector General, Department of Health and Human Services, *Variation Among Home Health Agencies in Medicare Payment for Home Health Services* (July 1995). Our 1997 analysis of a small sample of high-dollar claims found that over 40 percent of these claims should not have been paid by the program. See *Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings* (GAO/HEHS–97–108, June 13, 1997).

begin to control spending, BBA implemented an interim payment system for HHAs beginning October 1, 1997. A PPS is scheduled to be implemented for all HHAs on October 1, 2000.[5]

Growth in Medicare Spending For SNF Care

As required by BBA, on July 1, 1998, SNFs began a 3-year transition to a PPS, under which providers are paid a prospective rate for each day of care. Previously, SNFs were paid the reasonable costs they incurred in providing Medicare-covered services. Although there were limits on the payments for the routine portion of care (that is, general nursing, room and board, and administrative overhead), payments for ancillary services, such as rehabilitative therapy, were virtually unlimited. Because higher ancillary service costs triggered higher payments, facilities had no incentive to provide these services efficiently or only when necessary. Thus, between 1992 and 1995, daily ancillary costs grew 18.5 percent a year, compared to 6.4 percent for routine service costs. Moreover, new providers were exempt from the caps on routine care payments for up to their first 4 years of operation, which encouraged greater participation in Medicare.

Growth in Medicare Spending for Outpatient Rehabilitation Therapy Services

Rehabilitation therapy comprises a substantial portion of the post-acute-care services provided by SNFs and other providers, such as rehabilitation therapy agencies and comprehensive outpatient rehabilitation facilities. Between 1990 and 1996, payments for outpatient rehabilitation therapy alone rose at an average rate of 18 percent a year, compared to 9.7 percent average growth rate for the same period for overall Medicare spending. BBA reforms were designed to control both the price and volume of therapy services provided in outpatient settings—the former by a fee schedule and the latter by per-beneficiary coverage caps.[6] Specifically, BBA limits coverage for outpatient therapy to $1,500 per beneficiary for physical therapy and speech/language pathology services, with a separate $1,500 per-beneficiary limit for occupational therapy. Hospital outpatient departments are exempt from these coverage limits.

Historical Overpayments to Medicare Health Plans

BBA sought to moderate Medicare's payments to managed care plans because beneficiaries who joined Medicare managed care cost—not saved—the government money. That is, the government was paying more to cover beneficiaries in managed care—an estimated several billion dollars more—than it would have if these individuals had remained in the traditional fee-for-service program. Medicare payments to managed care plans have been estimated to be too high by as much as 16 percent.[7] Beginning in 1998, BBA made several changes to the method used to set Medicare+Choice plan payments, not all of which will reduce excess payments. Among other things, BBA required a new risk adjustment method—a mechanism for adjusting payment rates on the basis of a beneficiary's expected annual health care costs. It will be implemented in two stages. Beginning in 2000, HCFA plans to phase in an interim method based on inpatient hospital data; in 2004 it plans to implement a more comprehensive method incorporating additional medical data from other settings. The interim risk adjustment, if fully phased in, would reduce payments by 7 percent. BBA also reduced updates to health plan payment rates for a 5-year period ending 2002, for a cumulative rate reduction of less than 3 percent. However, the effect of these reductions is substantially moderated because BBA used 1997 payment rates as the foundation for rates in 1998 and future years. According to HCFA actuaries, a forecast error caused the 1997 rates to be an estimated 4.2 percent too high and, consequently, aggregate plan payments in 1998 were $1.3 billion too high. The excess payments resulting from this forecast error

[5] BBA required the HHA PPS to be in place on October 1, 1999. Subsequent legislation delayed the implementation by 1 year, eliminating any transition period.

[6] Payments for inpatient rehabilitation therapy services, such as those provided by SNFs, HHAs, and rehabilitation facilities, are not subject to the fee schedule and are paid under other rules. In addition, outpatient therapy provided by critical access hospitals is not subject to the fee schedule.

[7] In a 1996 study, HCFA estimated that payments were too high by 8 percent in 1994. [See Gerald Riley and others, "Health Status of Medicare Enrollees in HMOs and the Fee-for-Service Sector in 1994, *Health Care Financing Review*, vol. 17, no 4 (Summer 1996)]. In a 1997 study, we estimated that aggregate payments to California plans were too high by 16 percent. [See Medicare HMOs: *HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments* (GAO/HEHS–97–16, Apr. 25, 1997)].

will increase over time with managed care enrollment because it is built into the base rate.[8]

Little Evidence to Date of Impaired Access to Home Health Services, but Future Payment System will Require Refinements

BBA'S new payment policies addressing rapid spending growth for home health care included the establishment of an interim payment system, which is currently in effect, and a requirement to replace that system with a PPS by October 2000. Our published and ongoing studies discuss the effects of these BBA payment reforms and concerns about their design and implementation.

Concerns have been raised about the effect of the interim system, but, as we reported in May 1999, there was little evidence that appropriate access to Medicare's home health benefit has been impaired.[9] The pre-BBA payment system had controls for payments per visit but left volume unchecked. Since enactment of BBA, home health agencies have been paid under the interim payment system, which attempts to control the costs and total volume of services. Indeed, our work indicates that overall home health utilization in the first 3 months of 1998 was below that in 1996 when Medicare spending for home health services nearly peaked. Moreover, the sizeable variation in utilization across counties has narrowed, a change consistent with the incentives of the interim payment system. Although these changes occurred at the time that about 14 percent of HHAs closed their doors to Medicare business, we found little evidence that beneficiary access to services was inappropriately curtailed.

Nevertheless, a home health PPS is a more appropriate payment tool because it can align payments with patient needs. Under PPS, payments will reflect the needs of the agencies' current beneficiaries rather than historical spending patterns. However, our ongoing work on this subject shows that a number of design issues remain, and the payment system will likely require continued adjustments even after implementation next year. It appears that HCFA intends to pay HHAs a per-episode rate for each 60-day period during which a patient receives services. Such per-episode payments are designed to balance competing goals of controlling service provision while giving HHAs flexibility to vary the intensity or mix of services delivered during the episode. Evidence indicates that HHAs do lower their costs in response to prospective payments for an episode of care. Whether they will inappropriately cut care remains to be seen. Under this prospective payment approach, HHAs also have incentives to increase the number of episodes of care provided, which could escalate, rather than constrain, Medicare spending. HCFA will need to adequately monitor service provision to ensure that beneficiaries receive the care they need and the number of episodes are not inappropriately increased.

The design of the case-mix adjustment mechanism is critical to adequately pay for patients with high service needs, yet not overpay for others with lower needs. Designing this mechanism requires detailed information about services and beneficiary characteristics, and such information is currently available only for a sample of users. Furthermore, the wide geographic and agency-level variation in service use indicates that standards of care are not well-defined, nor are the criteria for who should use the benefit. As a result, the factors that will be used under PPS for grouping patients with similar resource needs may not adequately distinguish among types of home health patients, and the PPS payment adjuster that will be associated with each patient group may not reflect appropriate cost differences. Systematic errors could result in overpayments for some beneficiaries and underpayments for others. Underpayments could lead to impaired access.

Large variations in historic spending patterns mean that a PPS, which will be based on average payment amounts, will undoubtedly cause payment levels to rise for certain HHAs and fall for others. Although the PPS may incorporate an outlier policy—that is, extra payments for extremely costly cases—additional mechanisms to moderate payment changes may be appropriate. For example, an "inlier" policy to reduce the payment for a patient who receives few services may be warranted, particularly given the fact that multiple episode payments may be made for a single beneficiary. Policies addressing both extremes of service use could protect the access of beneficiaries with high needs and protect Medicare from overpaying for low-cost

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[8] BBA did not allow HCFA to adjust the 1997 rates for forecast errors, although such adjustments had been a critical component of the pre-BBA rate-setting process. BBA permits HCFA to correct forecasts in future years but did not include a provision to allow a correction of its 1997 forecast.

[9] *Medicare Home Health Agencies: Closures Continue With Little Evidence Beneficiary Access Is Impaired* (GAO/HEHS–99–120, May 26, 1999).

cases. A risk-sharing method, to account for cost differences across agencies, could provide further protection against underpayments or overpayments. Given the heterogeneous use of this benefit and the unresolved PPS design issues, moderating payments through risk-sharing might be warranted, even though such a mechanism would weaken HHAs' incentives to provide care more efficiently.

Aggregate Payments to SNFs are Adequate, but Refinements Needed to Help Match Payments to Patients' Service Needs

Despite industry charges to the contrary, SNF payment rates under BBA are likely to provide sufficient, or even generous, compensation for providers. Nevertheless, the distribution of these payments may be out of balance, because the current case-mix adjustment method may not adequately ensure that providers serving high-cost beneficiaries are paid enough and that those serving low-cost beneficiaries are not paid too much.

Under the new PPS, SNFs receive a payment for each day of covered care provided to a Medicare-eligible beneficiary. By establishing fixed payments and including all services provided to beneficiaries under the per diem amount, the PPS attempts to provide incentives for SNFs to deliver care more efficiently. Under the PPS, SNFs that previously boosted their Medicare ancillary payments—either through higher use rates or higher costs—will need to modify their practices more than others. Scaling back the use of these services, however, may not necessarily affect the quality of care. There is little evidence to indicate that the rapid growth in Medicare spending was due to a commensurate increase in Medicare beneficiaries' need for services.

Recent industry reports have questioned the ability of some organizations that operate SNF chains to adapt to the new PPS. Indeed, Medicare payment changes have been blamed for one corporation's filing for protection under bankruptcy law and the potential for another to similarly file. However, our ongoing work suggests that the PPS should not have an untoward impact on most SNFs and is only one of many factors contributing to the poor financial performance of these corporations. For most SNFs Medicare patients constitute a relatively small share of their business. In addition, the PPS rates are being phased in, to allow time for facilities to adapt to the new payment system, and most of the payments are still tied to each facility's historical costs. However, heavy investments in the nursing home and ancillary service businesses in the years immediately before the enactment of BBA, both to expand their acquisitions and upgrade facilities to provide higher-intensity services, has created difficulties for some corporations. Now under tighter payment constraints for both their SNF and ancillary service operations, these debt-laden enterprises will not be able to rely on overly generous Medicare payments. Thus, while PPS does represent a constraint on Medicare revenue and SNFs will have to adapt, the performance of some large post-acute providers is a reflection of many Medicare payment policy changes and strategic decisions made during a period when Medicare was exercising too little control over its payments. We are gathering additional information and will report soon on the effect of the PPS on SNF solvency and beneficiary access to care.

We believe that overall payments to SNFs are adequate. In fact, we and the Department of Health and Human Services Inspector General (HHS IG) are concerned that the PPS rates Medicare pays may be too generous. Most of the data used to establish these rates—from 1995 cost reports—have not been audited and are likely to include excessive ancillary costs due to the previous system's incentives and the lack of appropriate program oversight.[10]

We are also concerned that payments for individual beneficiaries could be inappropriately too high or low because of certain PPS design problems. The first of these involves the patient classification system. The classification system was based on a small sample of patients and, because of the age of the data, may not reflect current treatment patterns. As a result, it may aggregate patients with widely differing needs into too few payment groups that do not distinguish adequately among patients' resource needs. In addition, the variation in non-therapy ancillary services costs does not appear to have been adequately accounted for in the payment rates, which may inappropriately compress the range in payments. Accordingly, access problems or inadequate care could result for some high-cost beneficiaries. Hospitals have reported an increase in placement problems due to the reluctance of some facilities to admit certain beneficiaries with high expected treatment costs, which will

[10] The HHS IG recently reported on the inappropriateness of the base year costs. See *Physical And Occupational Therapy in Nursing Homes: Cost of Improper Billings to Medicare* (HHS IG, OEI–09–97–00122, Aug. 1999).

increase hospital lengths of stay for these patients. HCFA is aware of the limitations of the patient classification system and is working to refine the system to more accurately reflect patient differences.

Another concern is that the current patient classification system preserves the opportunity for SNFs to increase their compensation by supplying unnecessary services. A SNF can benefit by manipulating the services provided to beneficiaries, rather than increasing efficiency. For example, by providing certain patients an extra minute of therapy over a defined threshold, a facility could substantially increase its Medicare payments without a commensurate increase in its costs.

Widespread Effect of Outpatient Therapy Caps Doubtful, but Need-Adjusted Payment Limits Would be Better

Questions have been raised about a BBA coverage restriction for a third group of post-acute-care services—outpatient rehabilitation therapy. Together with a fee schedule that replaces reasonable cost reimbursement for these services, BBA established an annual $1,500 per-beneficiary cap on payments for outpatient physical therapy and speech/language pathology services combined and a separate $1,500 per-beneficiary cap on outpatient occupational therapy.[11] Services provided by hospital outpatient departments are exempt from the per-beneficiary caps.

Rehabilitation therapy providers have raised concerns that the $1,500 limits will arbitrarily curtail necessary treatments for Medicare beneficiaries, particularly victims of stroke, hip injuries, or multiple medical incidents within a single year. These concerns have led to several legislative proposals to include various exceptions to the caps or eliminate them altogether.

Our ongoing work on this topic suggests that eliminating the caps without substituting other controls could undermine BBA's comprehensive strategy for restricting payments for outpatient therapy services. Controlling the price for each unit of service—as is done with the new requirement that outpatient therapy providers be paid using Medicare's physician fee schedule—may not necessarily control Medicare expenditures if utilization rises. This is particularly likely, given the price and utilization controls established through PPSs on other providers of rehabilitation therapy. Thus, the per-beneficiary caps serve to limit the volume of services provided.

For the vast majority of beneficiaries, the coverage caps are unlikely to curtail access to needed services. An analysis by the Medicare Payment Advisory Commission shows that, in 1996, most users (86 percent) did not exceed $1,500 in payments for physical therapy and speech/language pathology services or for occupational therapy.[12] Moreover, as the fee schedule likely reduces payments for many providers, the proportion of beneficiaries that are unaffected by the caps could be even higher in 1999 because beneficiaries could receive more services before reaching the per-beneficiary caps than under the former cost-based system.

Even for beneficiaries exceeding $1,500 in payments under the fee schedule, mitigating factors exist. First, under the BBA exemption, Medicare beneficiaries have no limits on coverage for rehabilitation therapy provided by hospital outpatient departments, which are widely available nationwide. In addition, the caps will initially not be applied as specified in BBA. Implementing the caps involves many programming changes to Medicare's automated information systems that HCFA is unable to undertake concurrent with its year 2000 preparation efforts. As a result, HCFA's claims processing contractors will be unable to track therapy payments on a per-beneficiary basis. Instead, effective January 1, 1999, HCFA employed a transitional approach to implementing the caps. Under this approach, each provider of therapy services is responsible for tracking its billings for each Medicare patient and stopping them at the $1,500 threshold. The consequence of this partial implementation is that noninstitutionalized beneficiaries may switch to a new provider when they have reached the $1,500 limit under their current provider.

The effect of the per-beneficiary caps on nursing home residents is less clear. HCFA's policy explicitly states that the hospital outpatient department exemption does not apply to those therapy services furnished to nursing facility residents. Moreover, the ability of beneficiaries to switch outpatient providers under HCFA's

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[11] Physical therapy includes treatments—such as whirlpool baths, ultrasound, and therapeutic exercises—to relieve pain, improve mobility, maintain cardiopulmonary functioning, and limit the disability from an injury or disease. Speech/language pathology services include the diagnosis and treatment of communication, swallowing, oral motor and related cognitive functions and their disorders. Occupational therapy helps patients learn the skills necessary to perform daily tasks, diminish or correct pathology, and promote health.

[12] A July 1998 report sponsored by the National Association for the Support of Long-Term Care and NovaCare, a rehabilitation services company, projects that 87 percent of beneficiaries will not exceed the per-beneficiary cap.

partial implementation approach is, practically speaking, not available to nursing facility residents. Under new billing requirements, the nursing facility in which the beneficiary resides is required to bill for outpatient therapy provided to the resident, regardless of the entity that actually delivered the service. Therefore, unlike their noninstitutionalized counterparts, nursing facility residents cannot switch providers to restart the $1,500 coverage allowance. Under these circumstances, some nursing home residents—like those needing extensive rehabilitation therapy resulting from such conditions as stroke or hip fractures—could be vulnerable to out-of-pocket costs for therapy.

Even the risk for these more vulnerable beneficiaries may be moderated, however, because nursing home residents seeking therapy for such conditions would likely receive a complement of rehabilitation services as a SNF inpatient—before the outpatient therapy coverage limit begins to apply. For example, individuals suffering a stroke or undergoing hip replacement would likely spend at least 3 days in an acute care hospital, which, combined with the need for daily skilled nursing care or therapy, would make them eligible for a Medicare-covered SNF stay of up to 100 days, during which they would likely receive therapy services. After their Medicare coverage period ends, nursing facility residents can continue to receive outpatient therapy services under Medicare part B, subject to the coverage limits. BBA mandates that HCFA develop a classification system based on diagnosis to determine differences in patients' therapy needs and propose possible alternatives to the caps in a report due January 1, 2001. This report will be significant in that a need-based system could help ensure adequate coverage for those beneficiaries requiring an extraordinary level of services and prevent overprovision to those requiring only limited amounts.

Medicare+Choice Remains Relatively Inexpensive for Beneficiaries, but Improved Risk Adjustment Needed to Target Payments Appropriately

Developing appropriate refinements to BBA reforms affecting Medicare+Choice requires consideration of several aspects of Medicare's managed care program. At the moment, plan withdrawals from Medicare+Choice in 1999, and recent announcements that additional plans will withdraw in 2000, have prompted debate about whether BBA reforms have resulted in inadequate payment rates. At the same time, our published and ongoing work indicates that Medicare managed care payments to health plans likely continue to exceed the cost of providing Medicare-covered benefits.

Our analysis of the 1999 withdrawals showed that payment rates alone could not explain plans' participation decisions. Withdrawals were not limited to low payment rate counties. The data suggested that local market conditions affected plans' participation in a county. A plan was more likely to withdraw from counties it had recently entered, where its enrollment was low, or where its market share was small relative to other plans serving the same county. Although our final analysis will not be available for a few weeks, our preliminary assessment suggests that similar factors help explain the pattern of the 2000 withdrawals.

Plan withdrawals may well reflect a normal market correction spurred by a changing business environment. Prior to BBA, health plans could expand into new areas with relatively little risk because overgenerous Medicare rates provided protection from the ill consequences of small enrollment or large competitors. Between 1993 and 1998, the number of plans and enrollees tripled. However, as BBA slowed payment growth, health plans may have reevaluated their expansion decisions, making such factors as potential enrollment, market share, and competition a key part of plans' decisions to withdraw from certain geographic areas.

A local example illustrates the importance of nonpayment factors in plans' participation decisions. In 1996, Blue Cross' Free State health plan in Maryland—which until that time had served only some of the state's large urban counties—extended service statewide. Free State recently announced, however, that beginning in 2000 it would substantially reduce its geographic service area. The plan is withdrawing from 17 rural and small urban counties even though BBA will increase the average base rate in those counties by nearly 6 percent next year. In contrast, the large urban counties will receive only a 2.4 percent average rate increase, but Free State will continue its Medicare participation in these counties.

According to industry representatives, it is difficult for health plans to serve counties with few providers and enrollees because providers have little incentive to discount their fees and plans cannot spread risk over a large enrollment base. Although we cannot know with certainty, these factors may have influenced Free State's decision to discontinue service in Caroline County and 16 other rural and small urban Maryland counties. For example, in Caroline County Free State faced

no competitors, had enrolled 19 percent of the beneficiaries, and would have received a 7.5 percent Medicare rate increase in 2000. However, less than 4,700 beneficiaries live in the county and Free State's 19 percent market share represented an enrollment of less than 900 beneficiaries. In contrast, the plan will continue to serve seven counties where the number of beneficiaries ranges from about 15,200 to 116,600.

In addition to our work on plan withdrawals, our assessment of BBA payment changes indicates that, relative to the cost of providing the package of traditional Medicare benefits, payments to health plans remain excessive. For one thing, plans annually receive a billion-plus-dollar overpayment in aggregate as a consequence of BBA's terms for setting the base payment rate. This problem, owing to an uncorrected forecast error, will be built into future base rates because BBA has not provided explicit authority for HCFA to correct the forecast error. In our June 1999 report, we suggested that the Congress consider certain modifications to Medicare's base payment rates to health plans to eliminate, among other things, the excess payments resulting from the 1997 uncorrected forecast error.

Moreover, payments continue to exceed plans' costs of providing Medicare-covered services. In 1999, the average plan was required to provide $54 in extra benefits per member per month so that projected Medicare payments would not exceed the plan's projected costs and normal profits. In addition, the average plan voluntarily provided another $54 in benefits per member per month. The additional benefits can be reflected not only in coverage for services, but also in reduced beneficiary cost sharing. For example, in 1999 most plans did not charge a monthly premium and charged only a small copayment for outpatient services.

In 2000, enrollment in a Medicare+Choice plan will remain a relatively inexpensive way for a beneficiary to obtain prescription drug coverage in many areas. On average, plans will charge beneficiaries $16 per month in premiums and most will offer prescription drug coverage. Beneficiaries will be charged a copay for prescription drugs that will average about $17 for brand name drugs and $7 for generic drugs. In contrast, the average monthly premium for private supplemental insurance policies (Medigap) offering, among other things, prescription drug coverage ranges from $136 to $194 per month in 1999. Moreover, those Medigap policies require a $250 deductible with a 50-percent copayment.

Given that Medicare has spent more for the generally healthier beneficiaries enrolled in Medicare+Choice plans than for the generally sicker beneficiaries in traditional Medicare, the need to have payments better reflect beneficiaries' expected health care costs is critical. HCFA's new risk adjustment method, based on certain health status measures, is scheduled for phased implementation in 2000 and represents a major improvement over the current method. For the first time, Medicare managed care plans can expect to be paid more for serving beneficiaries with serious health problems and less for serving relatively healthy ones. The method scheduled for implementation in 2004 will be an improvement over the method used in 2000 because it is intended to include better health status measures derived from more comprehensive data not currently available.

HCFA's plan to phase in the 2000 risk adjustment method slowly is designed to balance the needs of taxpayers and beneficiaries. In 2000, only 10 percent of health plans' payments will be adjusted using the new method. This proportion will be increased each year until 2003, when 80 percent of plans' payments will be adjusted using the interim system. Although a gradual phase-in of the interim risk adjuster delays the full realization of Medicare savings, it also minimizes potential disruptions for both health plans and beneficiaries. In 2004, HCFA intends to implement a more finely tuned risk adjuster that uses medical data from physician offices, outpatient departments, and other health care settings and providers—in addition to the inpatient hospital data on which the interim adjuster is based. This more comprehensive risk adjustment system cannot be implemented currently because many plans say they do not have the capability to report such comprehensive information.

Conclusion

In conclusion, BBA payment reforms seek to curb unnecessary Medicare spending. As the reforms begin to have their intended effects, pressure is building to return to more generous payment policies. Evidence to date shows that BBA is moving Medicare in the right direction but that adjustments will be needed along the way. These adjustments should be based on thorough, quantitative assessments so that misdiagnosed problems do not lead to misguided solutions. With the health care of seniors and the tax dollars of all Americans at stake, it will be prudent to uphold

new payment policies that exact efficiencies but make adaptations when substantiated evidence supports the need to do so.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Subcommittee might have.

Chairman THOMAS. Thank you, Bill. I hope no-one assumed that once we began this process that we weren't just going to pass BBA '97, fire and fall back and not monitor. In fact, included in the legislation was the creation of a bipartisan Medicare reform commission to begin looking at the out years. The suggestions that that commission came up with, the recommendations, although falling short of the 11-vote super, super, super majority required will, I can assure everyone, surface in bipartisan legislation with additional refinements as we move forward.

One of the more interesting areas we have been examining is the fact that Medicare has to go out and the plans under Medicare have to go find their beneficiaries one at a time, the most expensive way to get people covered, and that we might be able to be fairly creative in terms of a bidding process that produces the most cost effective plan being rewarded by some beneficiaries who have signed up, not knowing which plan they are going to, but with the promise that it would be a zero premium, and thereby at least mitigating some of the relatively high costs for marketing a product which under law doesn't have a whole lot of ability to be varied except for, as you indicated now, about $54 of additional benefits. That is just an aside in terms of some of the things that we are continuing to do.

Thank you. And we are going to ask for MedPAC's additional recommendations. You have some included in here. The key here is for us to know as best you are able whether it is going to require legislation to make the change or whether you believe administratively the changes could be made. Then whether they will be made or not administratively is another question. I do think that the therapy cap is going to have to be legislated, especially if we create some kind of a pool as well as modify the caps.

I think there is some room for budget neutral adjustment on the SNF drug structure but fundamental additional money for acuity I think also needs to come from us, and we are willing to do that.

Are you comfortable or do you need some additional analysis to make some statement about the outpatient prospective payment capability of the administration in the basic form? Do you believe that they have the administrative ability to phase it in and/or make it budget neutral in that stretched out phase-in or do you want to take a look at it and come back with a recommendation?

Ms. WILENSKY. We will come back with a recommendation. The answer has to do with whether, if the statute doesn't explicitly say it can't be phased in, does that give HCFA the ability to do so, or if the legislation says these are the savings to be produced by introducing a prospective payment at a particular point in time, does that limit how it can be introduced. We will come back with an opinion from the attorneys on our staff.

Chairman THOMAS. I think it probably falls under the general category of affairs, if there is a will, there is a way, and hopefully we will be able to work our way through that.

The concern that you have is a concern that I have, and this may be a legislative requirement, that notwithstanding the phasing in, and even if it were possible to make them budget neutral, there are still going to be significant differential payments, and perhaps we might think about building some corridors in terms of plus or minus percentages so that instead of one big river you can channel those payments where they might be most appropriate. If in fact we do do that, that is, a refinement that I think is going to require legislation, and in the short timeframe we are dealing with that may not be appropriate, but we are going to have to monitor that very carefully.

Ms. WILENSKY. It does, of course, not take effect until next summer, and so it gives you, an opportunity to revisit this issue, if you wanted to.

Chairman THOMAS. And while you are looking at the budget neutral aspect, we, probably in a very short timeframe, request you look at again the risk adjuster under Medicare+Choice, an objective analysis of whether they can. Whether they want to or not of course would be a different question, but whether you believe it would require legislation to make that change, and as is usually the case, we want all the answers to these on Monday morning, preferably before noon, if possible. Thank you very much.

Ms. WILENSKY. I understand. I trust the executive director will have no problem having that back to you.

Chairman THOMAS. And Michael Hash has learned, as have you, you just pass that baby on. We are getting from behind you.

Ms. WILENSKY. It was my years at HCFA that helped me learn this trick.

Chairman THOMAS. Exactly. We do need these in a relatively short period of time. Thank you.

Does the gentleman from California wish to inquire?

Mr. STARK. I would like to ask Gail, I just reviewed your career here for a minute. You used to run HCFA, didn't you?

Ms. WILENSKY. Indeed, I did.

Mr. STARK. In those days, you were a Republican. Now, you have to be bipartisan, right, and nobody ever questioned your conservative philosophy, did they, when you were working for the Republicans?

Ms. WILENSKY. Not to my face. I don't know what they said otherwise.

Mr. STARK. Now, the Democrats are running HCFA. You and Dr. Newhouse cosigned a letter recently talking about the operating budget of HCFA, and just if I can review for my colleagues, and I am sure you are aware of this, but basically HCFA had asked for a couple of percent increase in their operating budget, about $70 million. There were also some additional user fees that were scheduled to come on stream in their proposal. The Appropriations Committee, I guess, assumed that we would enact the user fees, and they cut HCFA's budget by 13 percent, or cut out $400 million. But, the fact is they are going to get cut $400 million and HCFA isn't getting the anticipated user fees.

My sense is we added a lot to HCFA's plate with the balanced budget amendment, and we are complaining often that they are not done with those duties. But, I wonder if you could comment—even let us assume you were going to go back and run HCFA—what do you think about HCFA's administrative budget? Shouldn't we be passing the user fees or doing something? And I want to talk to Dr. Scanlon about this a minute, but could you, in a kind of bipartisan way, weigh in on that?

Ms. WILENSKY. As you noted, both as an individual and then again as a member of MedPAC, I think there has been a mismatch between the requirements and burdens that had been placed on the agency as a result of the Balanced Budget Act in turns of the resources that are available. I don't think it is appropriate and MedPAC has not looked at how the funding decision should be made, whether it should follow the normal course or an extraordinary course. MedPAC is concerned that there needs to be a decision either to lessen the activities that you assign HCFA or to provide more administrative support because otherwise you find, to the Congress' frustration, that some of the activities don't get done in a timely way. We realize this is a difficult discretionary spending year, but I am personally concerned about this as well.

Mr. STARK. And I ask Dr. Scanlon, along the same line, though this may be going a little further. Could we fix it this year like we pay the PROs directly out of the trust fund, I believe. We changed the way. The Medicare integrity program is paid in Kennedy-Kassebaum Act. In your opinion, if this is a fair question, could we not pay the HCFA operating budget directly out of the Medicare trust fund and build in adequate safeguards for auditing and oversight?

Mr. SCANLON. I think we see from the Medicare integrity program example under the Health Insurance Portability and Accountability Act the model in some respects for providing both the oversight, as well as the certainty about the funding that HCFA would have available. We have commented, in looking at HCFA's operations in the past, about the difficulties that are created by the appropriations cycle and the fact that appropriations are often delayed and that this delays the initiation of activities. This was particularly a problem in the fraud and abuse area. The contractors were not certain how much they were going to have, and therefore, a portion of the year would expire, and they really would not have begun the kinds of activities that would have produced positive results.

Mr. STARK. And as an expert in government policy, if this Committee had oversight of HCFA's operating budget, wouldn't you think that HCFA would be far more responsive to the chairman's requests just as a matter of self-survival?

Mr. SCANLON. My graduate degree was in economics, not in government policy.

Mr. STARK. One further question. Gail, I have puzzled over this for years. For a while the California Hospital Association used to collect data on hospitals, showing all of their income and all of their expenses and showing their charitable contributions and all the rest. Now the hospitals say they don't want to tell us. Is there any reason that you can think of, even if it had to be sanitized so

that we only had it by State and we didn't know the names of individual hospitals, that we should not, in this era of computers, be getting relatively detailed financial statements from every hospital, indeed every provider in a format that was at least the same for each institution so that we could begin to compare by area, by size of hospital, by all of these things where the problems are? Without that information it makes it very difficult for us to perhaps offer the best help to those institutions that need it most. Is there something that prevents that?

Ms. WILENSKY. I think I recall this discussion from 8 or 9 years ago. We certainly have got to do better than we are doing now. It is ridiculous in an age of information that we are operating on old and, if not irrelevant, sufficiently dated information that we can't properly advise you and you have difficulty making the best decisions. Exactly how to put it in a common format so that the information is available with the privacy protection that is needed, I am sure would be subject to debate by the institutions affected. However, we clearly need to fix the problem we are now facing, and I think it is in the institution's interests right now to do so.

Mr. STARK. Thank you.

Chairman THOMAS. Just let me briefly, before I recognize the gentlewoman from Connecticut, indicate that there is always a concern about bureaucracies and how much money they get and how much money they need. In the President's fiscal year 2000 budget request, HCFA asked for over $50 million to develop a database for the risk adjuster. Some of us remember something called the Medicare transaction system, MTS. I believe Dr. Scanlan at GAO did a study on that. How much was spent on the Medicare transaction system before they canned it?

Mr. SCANLON. As I remember, around $43 million was spent on that.

Chairman THOMAS. So one of the problems I would tell the gentleman is that notwithstanding their desire to get money, there is still in my opinion a significant unwillingness to face reality where they spend tens of millions of dollars on programs that aren't going anywhere without admitting that they aren't going anywhere until the cost is so high. I think you will find if you examine previous budgets it could have been as much as a hundred million that was focused there, and we never got a return on our investment.

Then let me say that one of the things that we absolutely need, and you are absolutely right, we do need data and we need to collect it in a confidential way so that individual patient identity is not divulged, and the gentleman from Maryland and I have a bill that we are going to introduce on patient records confidentiality which will address that problem.

Last, in your report, and I apologize for not asking you this earlier, you talked about the impact that PPS would have on particular types of hospitals, especially rural and cancer hospitals. In the BBA there was a requirement of a 1-year delay of the imposition of any prospective payment system, for example, on cancer hospitals. If we maintain the current law relationship of a 1-year delay between the introduction of a PPS system and an examination as to whether it should be applied to particular hospices, like cancer hospitals, do you think that is a sufficient safeguard to

make sure we get the system right or do you think we should exempt them up front before we have any of the data and the 1-year delay to examine it? What would be the prudent approach in your opinion?

Ms. WILENSKY. I think we ought to have the 1-year delay. I don't think at this stage exempting them without further analysis is appropriate. I know there is concern about what happens in the cancer hospitals. I also know that some of the academic centers that provide major cancer care challenge that there is quite the difference that the cancer centers claim. We have heard that on the commission already. So I think that having an ability to look at this issue and try to decide how not to adversely affect these centers before we make a decision is better than simply exempting them.

Chairman THOMAS. While I certainly would not support a position of imposing a PPS on all hospitals at the same time and that I think was the reason we built the 1-year delay in, I still think it is the prudent approach, and I appreciate your testimony.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON of Connecticut. I guess I am disappointed, Dr. Scanlon, in any sense of urgency in your testimony. I think we have been fortunate that we aren't seeing real access problems in the nursing home area, and I think it is because most of the nursing homes are really dedicated to their work and are trying hard to provide the same level of care they have always provided, but if we don't begin to take note of the fact that somebody with a $10,000 prosthetic device is different from somebody who doesn't have that need, then we are going to have serious problems. We don't begin to be able to have real-time, you know, real life recognition of drug costs. They are so much more a part of treatment, not just in an outpatient, but in nursing homes. We are going to have real problems, and I think if you listen to the testimony later on, you will hear that we are on the verge of that.

The majority of people trying to discharge patients from hospitals are finding high cost patients hard to place, and I am tired of looking at the faces of very kindly people who run wonderful, quality care places, looking at me and saying how can I honestly, ethically, morally take into account whether this person is going to cost them a whole lot, but how can I not, in respect to the fiduciary responsibility I have to keep the home open.

So I want to say I feel a sense of urgency to address some of the problems that the BBA has encountered and to address some of the problems that the administration has created by the way they have implemented it, and I think we are going to have to look at urging the administration to use their executive branch power to eliminate prosthetic devices from the average payment system, transportation for dialysis when it can't be delivered in the home. So it is not a big number of things, but there is some sense of urgency of what needs to be done now, and I really am disappointed. I don't get that sense of urgency.

There is just simply too many questions to need to go into. So let me ask you both a general one that I think is extremely important. Hospitals are, in my estimation, really in a difficult situation, and we are going to erode institutions that are of extraordinary im-

portance, not just to Medicare patients but to every American in their neighborhood and their community. I see my hospitals, the small hospitals beginning to dig into their endowments. This can't go on many years before you don't have a strong institution.

So when you look at teaching hospitals, one way to alleviate the immediate stress, until we get a better handle on the complex variety of changes in the public and private sector that is impacting these institutions, would be to freeze IME payments for 2 years and DSH payments. The number of uninsured is going up. Their responsibilities for indigent care is not declining. Medicare managed care choice programs are the poorest payer of all of the managed care plans in my part of the country.

Now, I may be feeling this more intensely than other members, because if you look at the study done by HCIA, they have a whole sort of section where they go into the fact that New England is more impacted by these decisions than other parts of the country because we have been officially run, I guess. I don't quite remember. I am sorry I didn't bring it. But I think we have to take the situation of the hospitals very seriously and at least protect them from further reductions in their inpatient reimbursement structure and particularly those reimbursement rates that have most to do with care for the poor and their unique role of training physicians and doing research. Many of them don't have the 25 percent match anymore for NIH clearance. So grants that they have traditionally had are beginning to be at risk.

So, you know, what would you recommend about payment changes for hospitals in this bill that we are going to develop?

Ms. WILENSKY. I would strongly encourage you to do something on the outpatient department, as I have indicated, both to lower the reduction in payment, to phase it in and to look at how aggregated the payment is. This would especially help teaching hospitals and rural hospitals because of the very large and active outpatient areas. I would not halt the IME reduction. As you know, ProPAC before us and HCFA have indicated that the indirect medical education payments are substantially over the costs associated with the indirect medical education.

I have personally—MedPAC has not taken a position on this. I personally have somewhat more sympathy on the DSH and the disproportionate share exactly because of the issue that you have raised. We know we have had an increased number of uninsured over the last several years, and while they are certainly not the sole providers of care and, in fact, have a mixed experience of how much all of the hospitals do, all the teaching hospitals do, I think if you have the funding, that to me would rank higher.

We will be able to come back in January and provide you in our March report a little better sense of how much of the increase in costs that is being reported is actually available in numbers. I have not seen the HCIA report that you have referenced, but we will certainly be glad to look at it.

Mrs. JOHNSON of Connecticut. Thank you. I hope you—I see my time has run out. I hope that you will, in your next round, look at what is happening to hospitals as a result of the increase in drugs. My community hospital in my own hometown has had a 43 percent increase in drug costs in the last 2 years. There is some drug they

have to give every infant that is very expensive, but you know, their moral and ethical responsibility requires that they administer it, and nobody reimburses them. So I think we need more immediate information and we need to take into account some things that in the past we really haven't had to take into account.

Are you concerned basically about the state of our teaching hospitals?

Ms. WILENSKY. I think they are certainly reporting that they are feeling pain. I have some question as to how much of it is related to Medicare to be very honest. I would like to have a better sense that these are BBA and Medicare issues. Otherwise, I think it is a much harder question. We have many academic health centers, and whether or not the whole configuration and the role of the Federal Government to the academic health centers, I am less convinced although the information, if it were to suggest otherwise would have me change my mind, that this is a Medicare payment problem. Although, as I say the outpatient change would help teaching hospitals a great deal. They have very active outpatient departments.

Mrs. JOHNSON of Connecticut. Thank you.

Mr. SCANLON. Mr. Chairman, if I might, I wanted to assure you, Mrs. Johnson, we do share your concern and your sense of urgency, even if our official language in the testimony does not convey that emotion.

We have recommended that the PPS for skilled nursing facilities be revised to deal with exactly the problems you are talking about, the high acuity patient as well as the very unique type of services that very few individuals are going to require, which potentially could be taken outside of the prospective payment system. We provided some information to Mr. Thomas yesterday about this very issue, and so we do share your concern there.

In terms of access to skilled nursing facilities, we are completing a survey very similar to the Inspector General's using another sample of hospital discharge plans. I am afraid our findings have been very similar to the Inspector General's in terms of not identifying significant problems. I am going to be very interested in looking at the testimony that is coming later to understand where their information fits relative to the information that we have, but again, we share the same urgency and concern.

Mrs. JOHNSON of Connecticut. Thank you.

Mr. Chairman, can I just make one comment to add to that?

Chairman THOMAS. Sure.

Mrs. JOHNSON of Connecticut. It is not just the small, country hospitals. Hospitals in the city of Dallas and Fort Worth, which almost all of them have merged because of financial problems, are having the same, exact problem, and they have stopped all capital expansion, even though they are 100 percent bed occupied because they are out of money, and they blame it on Medicare whether you want to realize it or not.

Ms. WILENSKY. I know and I actually just came this morning from Texas. I understand that they blame it. We need to be able to advise you to assure ourselves that it is actually Medicare and not other changes.

Chairman THOMAS. Unfortunately, one of the fundamental problems in America today is there are too many hospital beds. They may not be in the right places, but there are still too many hospital beds.

The other concern I have is that this is the first round of significant adjustments. MedPAC recommended to us that the 7.7 reimbursement rate on indirect medical was probably too generous. We are talking about going to 6.5. In fact, MedPAC has recommended a number perhaps below 5 as the appropriate amount. I think part of this is simply a test of wills. If some folks with significant leverage can hold the line now, we will not be able to go ahead and make the kind of reforms that are necessary over the long haul.

What we need desperately is accurate information so that we can make the most reasonable decision. We will try to be as prudent as possible, but it seems to me that moving from 7.7 to 6.5, when we are looking at a glide slope that will extend over several years, is simply an indication that the entire graduate medical education area needs to be reexamined, not just the modification in the current rates, and we intend to do just that.

Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman. We do have a couple of minutes before the vote. I have a question of Ms. Wilensky.

You have indicated in your remarks that you believe the nursing home problems should be addressed in this, what we call refinement legislation. I happen to agree with the gentlelady from Connecticut on this subject. I hear stories from nursing homes and patients in my District where the high acuity patients are being left in the hospital because nursing homes are refusing admission. I can't fault the nursing home because they are not in the business to lose money or to harm the solvency of the home or to hurt other patients.

They know that when a high acuity patient walks in the door they are going to be losing big, big dollars. There is no way that they can do that. So now they are advocating, the profits or nonprofits alike for some changes in the RUG rates. Can you give this Committee some specific advice and/or recommendations as to what adjustments should be had in that area? Some of the nonprofits homes are looking for relief in the extensive services and special care areas. Other nursing homes are looking for relief only in the rehab area. The Hatch bill I think for the most part deals with the rehab RUGs and slates them for increases. Give us some direction on this particular issue.

Ms. WILENSKY. The staff that have been working in this area in MedPAC I know have met with the committee staff on several occasions discussing the fact that some of the bills have many categories. Some of the bills are much more focused. We also have looked at the issue of keeping some potential areas outside of prospective payment, for example, ambulances. Mrs. Johnson identified a case with regard to dialysis. Perhaps if there is no financial relationship between the nursing home and the ambulance company, that there may be circumstances where the separation outside of prospective payment would be reasonable.

We will make sure that there is——

Mr. KLECZKA. Do you have a list of those?

Ms. WILENSKY. We will make sure——

Mr. KLECZKA. What RUGs are you looking at? What RUGs would you suggest that we address?

Ms. WILENSKY. I am sorry?

Chairman THOMAS. If I can respond to the gentleman. His question was what RUGs to adjust. The difficulty is that the computers at HCFA won't allow us to adjust the RUGs. What we are going to have to do is find a surrogate for acuity and then create a multiplier for IVs, hospital beds. There are ways to create surrogates in the interim.

Mr. KLECZKA. The question is not how it is going to be done. The question is, could you identify for the Committee which areas you think should be given priority for adjustment. We will worry about how to do it.

Ms. WILENSKY. We will attempt to do so. I don't know whether the staff has already laid that out. I do know, because I was involved in some of the discussion, that we have met with committee staff on the general issue, but we will make sure that we have as much assistance on the specifics as we can.

Mr. SCANLON. If I could add, I think one of the original difficulties——

Mr. KLECZKA. I am sorry.

Mr. SCANLON. I was going to add to this. One of the original difficulties in setting up the RUGs was the very small sample of patients that was being used, and there is the strong potential that what happened is in the highest categories in terms of nursing need and in terms of rehabilitation need that there were too few patients, and therefore, the grouping is too gross, and what we need to do is think about dividing that group up. The problem that HCFA has faced is that they need more information about patients and the variation of needs, and they are going about trying to collect that. We really shouldn't make this decision based on intuition. We should be basing it on data they are trying to collect.

Ms. WILENSKY. My understanding is there is a contract out right now that is supposed to provide data back to HCFA by the end of the year. The question really is, is there something the Committee wishes to do in the interim in what is a widely agreed upon problem while HCFA gets more precise data to actually make an informed decision about which of those categories is underpaid and by how much. My understanding is that if you want to do something right now, it will be on limited information and HCFA will have a limited ability between now and next summer to implement something that is very sophisticated because of all the Y2K and payment issues. My personal opinion is it would be better to go ahead and do something now and something more refined next year.

Mr. KLECZKA. OK. Would you please share your specific recommendations with regard to short term changes with the minority staff?

Ms. WILENSKY. Yes, of course.

Chairman THOMAS. Thank you very much. I am informed that we are going to have another vote following this vote, and so it is going to be very difficult to try to continue the Committee. If I could ask you, is it going to be possible for the panel to come back

so that other Members could quiz them, and that to give everyone some assurance and perhaps an opportunity for lunch, let us say that the Subcommittee will reconvene at 1:30. Thank you very much. The Committee stands in recess.

[Whereupon, at 12:45 p.m., the Subcommittee was recessed, to reconvene at 1:35 p.m.]

Chairman THOMAS. The Subcommittee will reconvene.

Does the gentlewoman from Florida wish to inquire?

Mrs. THURMAN. Thank you, Mr. Chairman. Dr. Scanlon, let me ask you, as you can tell from some of the conversations that we have had with the different witnesses, all of us have been asked to look at some of these issues and the impact of BBA, and yet we are hearing today that there doesn't seem to be all that many problems out there, everything is OK. But one of the things that I would like to ask you is, one of the concerns that I have is, things, as I think Mrs. Johnson mentioned and others have mentioned, that things may be not, you may not be able to identify potential problems in the future, and so one of my concerns is that if we don't do some of the things that are being asked by some of these providers, do you see in the future some real cuts in patient care?

Mr. SCANLON. Let me start by saying I think we don't want our testimony to be interpreted as saying that everything is OK. I mean, we think that generally speaking there is still care being delivered to serve beneficiaries' needs, and we have identified some problems that exist, and in some instances, those problems relate to where a person receives care as opposed to whether they receive care, the example being the skilled nursing facilities. When people remain in the hospital, they are still being cared for, they still may be receiving therapy. We heard from discharge planners that sometimes their hospital stay is extended long enough that they are able to go home with home health care instead of going to a skilled nursing facility for a short stay.

So we do think that those are things to be noted, and at the same time, we think that the issue is fixing or refining these various systems in terms of dealing with the problems that we have identified, which are, generally speaking dealing with higher-need beneficiaries. This is the case for problems related to home health, Medicare+Choice, skilled nursing facilities. How much those will become exacerbated over time, I mean that is a concern. So we do need to try to address those.

Our other bottom line is we feel there are enough resources in the system, but, there is a targeting question because we can still identify areas of overpayment. So that in terms of trying to deal with the areas of underpayment, we need to think about some redistributions as well as potential infusions of new money.

Mrs. THURMAN. What about in the area of hospitals? Because we are hearing from our hospitals, and they are saying, look, we are holding on barely, and we think if this continues and we don't get any relief, that you really will see some patient—and I am hearing that from private, from community, from not-for-profit, and in particular, some of my teaching hospitals, the same kinds of things. What can you give us as some hope here?

Mr. SCANLON. Maybe it is more information as opposed to hope. I think the issue is that we have not done nearly as much or really

haven't looked into the hospitals per se, leaving that work to MedPAC, and I would ask Dr. Wilensky to comment on that.

I do think the one area where the work that we have done indicates an impact on hospitals consists of those people who are staying longer and not being placed in skilled nursing facilities. Hospitals are in many instances not getting additional revenues to serve those longer-stay patients. But the whole issue of hospitals, as we talked about this morning, is tied to what other payers are doing and to the supply of hospitals we have relative to the need. There has been a dramatic change in the delivery of medical care and we use less inpatient hospital services. So it is a question of what is Medicare's role in resolving this more general set of problems that are affecting hospitals.

Ms. WILENSKY. I think your concern is well placed because I know you have been visited by representatives of the health care industry broadly defined, but you will have opportunities to make further corrections. Many of the statements relate to projections 3 and 4 years out. If they continue, this is what will happen. I do urge you to do some things this year, I don't want you to misunderstand me, but I think you ought to concentrate in the areas where it is clearer this is a problem right now, monitor what is going on. We come back to you with at least two reports a year. We will have more information on the hospitals. The outpatient we think we can see now coming as a problem. It is not clear that there is currently a problem on the inpatient, and I agree that there are probably more hospitals than we really need, and if we could have some selective closures, it would be helpful.

Mrs. THURMAN. And I do note that you do say that there are other indicators, pressures that are going on out there. What would be the kinds of questions that we should be asking for information from our hospitals to help us make this clearer and to identify those issues that we really need to be working on this year?

Ms. WILENSKY. The biggest thing that would be helpful would be to get information that separates out the effects from Medicare versus the effects that are going on from other payers in the hospital. We are also sometimes presented with data from individual hospitals. It is not showing that separation. It is unreasonable to ask a fiscally fragile program like Medicare to make up for pressures going on from other payers, and so that is really something that we need to know. We know that in the past few years hospitals have been very good at keeping their costs down. So although Medicare payments weren't rising that quickly, it allowed for a substantial inpatient margin to build up.

We want to see what has happened with the costs, whether they have been able to keep them low. We know the revenue has been—was frozen and is now growing very, very slowly. My guess is, there are still, in the most part, Medicare margins inpatient. The outpatient is a different problem, but if there is something else, we need to be able to see it. We can't see it.

Mrs. THURMAN. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. I would tell the gentlewoman from Florida, one of our biggest problems is that we haven't had change in this area for such a long time.

A piece of humor here is news from the 13th District in California. It is a press release. The headline is, Medicare vastly overcharged for infusion therapy provided in skilled nursing facilities prior to Balanced Budget Act. "The IG's findings are a classic example of how Medicare was ripped off under the old cost-based system," Representative Stark said, chairman of this Committee for more than a decade in which, if he had been willing to make some of the changes that clearly needed to be made, especially in SNFs and in home health care, we would not see the growth that occurred and, therefore, the significant need to make dramatic adjustments that we are now faced with.

Does the gentleman from Minnesota wish to inquire?

Mr. RAMSTAD. Thank you, Mr. Chairman. Dr. Wilensky, Dr. Scanlon, good to see you both.

Dr. Wilensky, let me ask you a question if I may. I was also glad to see in the most recent MedPAC report that the commission recommended that the Secretary should postpone by at least 1 year the application of the interim Medicare+Choice risk adjustment for specialized plans such as EverCare, and you were here for my line of questioning to the previous witness, and I am quoting now from your report:

> Plans should be paid using existing payment methods until a risk adjustment or other payment system is developed that adequately pays for care for frail Medicare beneficiaries.

Now, my question is this, if plans should be paid under the current payment system until a special methodology is developed for these frail elderly programs, why didn't MedPAC go one step further to recommend that these programs should be completely exempted from the internal risk adjuster at least until the new methodology is implemented?

Ms. WILENSKY. It would be a better system if we could bring them into a single payment mechanism, and it is really a question of how long will it take until we are at that point. So we were trying to buy some time until—there is a current evaluation being done of the PACE, EverCare and Social HMO programs. We wanted to get more information back that shows the impacts of these programs. There is an outstanding study with regard to whether the for-profit, not-for-profit distinction is of any use. We decided to withhold further recommendations until these outstanding studies are done. We actually had considered making a stronger recommendation, but because there are several studies relating to these programs, we thought it was more prudent to wait until the information is back. We will be back next year and say something. So we brought what we thought was the most important point, which was don't do anything for now until we can come back next year and see if there is anything more specific to say.

Mr. RAMSTAD. That data should be available, should be forthcoming by when, would you say, early next year?

Ms. WILENSKY. My understanding was in enough time so that when we came back in June 2000 we would have additional information. I will provide you that when the studies are supposed to be completed.

Mr. RAMSTAD. OK. I certainly appreciate the commission's recognition of the importance of specialized plans, specifically

EverCare. It affects so many of the frail elderly in Minnesota and Maryland, Mr. Cardin's State and district, across the Nation as well, as Mr. Cardin pointed out earlier.

In the remaining couple of minutes I have got, I am also concerned that the annual lock-in requirement will be detrimental to these frail elderly programs. Thirty percent of the membership dies in any given year, and if members are only allowed to enroll once a year in these programs, obviously many of them won't have the opportunity to avail themselves of these high quality, innovative, cost-saving programs. What is MedPAC's position on the once a year annual enrollment requirement?

Ms. WILENSKY. We did have discussion concerning precisely about the issues you have just raised. I don't recall that we took a position specifically on that issue. I will go back to look and if we did, I will let you know. Prior to our report next year, I will make sure that we have looked at this issue.

Mr. RAMSTAD. Now, it is my understanding that MedPAC recommended exempting the PACE program from the annual lock-in provision. Is that correct? I believe that was exempt.

Ms. WILENSKY. I believe that is correct. The issues that we were dealing with is that we had the outstanding study work was primarily to be done on the EverCare and the Social HMOs. Those are evaluations that had been requested and had not been completed. It was really waiting to that time.

Mr. RAMSTAD. My point is, implicit in my question is, if the PACE program can be exempted from this annual requirement, couldn't this also be done for the EverCare program?

Ms. WILENSKY. Yes. Again, the point of our concern was we did not want to do harm to these programs. We think it prudent to get this additional information, but we agree this is something that if you undo the programs it will take a while to put them back together.

Mr. RAMSTAD. Finally, Dr. Wilensky, just a footnote to my friend from Florida's statements. I was just at the Mayo Medical Center in Rochester, Minnesota, which operates, as you know, under one of the lowest profit margins of any provider in the world and also some of the highest quality health care of any provider in the world. They attribute to the BBA changes a loss over 5 years of $500 million, and they can't absorb $500 million. So I think this problem is more widespread than some of us recognize.

Mr. RAMSTAD. Or at least some of our friends at HCFA recognize. Thank you.

Chairman THOMAS. Thank the gentleman. The gentleman from Maryland wish to inquire?

Mr. CARDIN. Yes. Thank you, Mr. Chairman. I want to agree with the comments made by Mr. Ramstad. It looks like we don't have much of a disagreement that we need to make some changes as relates to the nursing home reimbursements, particularly as it relates to acuity of patients, and have to do something with the therapy cap, outpatient services. There is an area where there appears to be an agreement where there is—I guess the difference is and emphasis is that many of us think it is an urgent issue that we have to deal with immediately. Quite frankly, I find it somewhat disappointing that we don't make modifications in the pro-

gram before we reach a crisis position. Before institutions go into bankruptcy or before patients are denied care, we should be looking at this and doing what is right before we reach a crisis position.

Dr. Scanlon, I want to question you as to one statement you made in your written statement where you say 2000 enrollment in Medicare+Choice plans will remain a relatively inexpensive way for a beneficiary to obtain prescription drug coverage in many areas. I take it in making that statement you looked at what has happened in this round of contracts between HCFA and the HMOs?

Mr. SCANLON. Yes, sir, we did look at that. And it is relatively inexpensive when one compares it to the Medigap policies that offer drug coverage. We have also been looking into that area in some other work and found the average premiums across the three different standard plans that offer drug coverage. They range from $1,600 to $2,800 a year. So that is the issue.

Mr. CARDIN. I appreciate the relative issue. But let me talk absolutes for one moment, if I might, and ask whether Maryland is an anomaly here or whether we are similar to other States; because when I see what will be available beginning January 1, 2000, in my State of Maryland, your statement even "relatively inexpensive" is just not accurate. Fourteen of our twenty-four counties will have no options on HMOs, and Maryland is not a very rural State. We are a rather urban State. But yet 14 of our 24 jurisdictions will have no plans.

In the 10 jurisdictions that will have plans, I am finding it difficult to find a plan available that doesn't have any very low cap unless you have a high premium. For example, in Harford County you can get into a plan without an additional premium, but the limit is $300 and the copayment for brands is $45, and $9 for generic. I wouldn't call that much of a drug coverage, would you?

Mr. SCANLON. It is very limited drug coverage, but that is the same situation that exists under Medigap. The lowest benefit in the standard Medigap plans is the $1,250 cap. That is the plan that has a $1,600-a-year premium. So for the zero premium you are getting $300 coverage. Certainly it is not good coverage, but the issue is relative to your choices if you remain in the traditional program.

We realize that before, 80 percent of the health maintenance organizations offering drug coverage were offering them at zero premiums. That was an incredible benefit for Medicare beneficiaries but at the same time the program was paying $54 a month above the cost of delivering the Medicare benefit package. That was an issue in terms of the overall sustainability of Medicare financing.

So we recognize what you did in BBA in terms of trying to put Medicare on a surer footing has an impact on beneficiaries. You need—we can't make the decision as to where the balance should be.

Mr. CARDIN. I think I agree with your point. I still take issue with comparing it to the Medigap plans because the Medigap plans actually provide, at least in my State, greater coverage than the Medicare+Choice plans.

Mr. SCANLON. Many Medicare+Choice plans——

Mr. CARDIN. I can't find a single plan in Maryland that doesn't have at least a $1,000 cap, and every one of those have pretty high premiums. So——

Mr. SCANLON. It is definitely true. The benefit has changed and declined relative to what it was before.

Mr. CARDIN. That is the point I would make—my time is running out. The last point I would make is that the statements have been made that the changes we made in reimbursement in 1997 is maybe one factor but maybe not even a significant factor in what the HMOs are doing. I take issue with that. I think that it is clear, I don't disagree with the fact that we ought to change the way that we reimburse Medicare HMOs, we certainly had to do that, but I think it is having a dramatic impact, at least on my State of Maryland, as to the plans that are available to our seniors, the affordability of those plans, and what it covers.

Mr. SCANLON. We don't underestimate the impact of the changing rates. It is just trying to deal with anomalies that we find. When we looked at Maryland, we looked at the withdrawal of the Blue Cross plan from the rural counties. We found that in those rural counties, the rates were going to be going up 5, 6 percent, whereas Blue Cross was staying in counties where their rate was only going to go up 2 percent. There didn't seem to be that much of a difference in the rural counties versus the urban counties in Maryland.

So how, when you get a more generous rate offer, you still withdraw and stay in an area where your rate increase is going to be lower, that is the thing that we haven't been able to explain just in terms of Medicare rates. We believe there are other factors that influence those as well.

Mr. CARDIN. There is a difference of $300 a month or more in what we pay the HMO plan between two counties that are next door to each other.

Mr. SCANLON. Not in the data that we have from the State of Maryland.

Mr. CARDIN. Oh, yes. In Maryland? The difference between.

Mr. SCANLON. In looking at counties that had rates of $480 to $500 where Blue Cross was leaving—and then the counties where Blue Cross was staying—it was not much more, certainly not $300 more.

Mr. CARDIN. But there is clearly between the——

Mr. SCANLON. I recognize that situation exists. It is just that it wasn't the case in terms of the Blue Cross decision in Maryland.

Mr. CARDIN. My time has run out. I disagree with that conclusion. Maybe we will have a chance later on to——

Mr. SCANLON. I would be happy to bring the data and share it with you. Thank you.

Chairman THOMAS. I thank the gentleman for the discussion, although it doesn't really focus narrowly on the BBA, the concerns that we have in front of us. It is clear and opens up the opportunity to talk about the fact that we have a basic disconnect very often. The way you are going to get realistic prices as opposed to artificially developed formulas by bureaucrats is to allow plans to negotiate for a price with real-world costs. And of course, that was the premium support model that the Medicare commission offered. The

difficulty with that is that if you want real-world prices, you have to accept real-world consequences. In terms of what happens in market situations, some people win, some people lose.

The idea of plans leaving shouldn't necessarily be a negative. It depends on what are the conditions, are there additional plans in the area, is it a market that is paying a rate which is attractive and would also cover the costs are a whole series of questions that need to be asked; not just if plans are leaving.

Mr. CARDIN. Will the gentleman yield?

Chairman THOMAS. I will as soon as I finish. The difficulty is that we have gone kind of half way. We created the so-called Medicare+Choice but we maintained them on formulas which I think the gentleman made an excellent case for, the artificiality of the formulas, especially the bizarre payments between counties in a close proximity simply because there is a county line or there is a metropolitan statistical area. Those anomalies have to be removed.

But if you are going to do that, you cannot then say that Medicare+Choice is a structure unto itself in which costs and quality will be judged and that dollars will be removed from that payment area and that you do not apply a cost and quality comparative to the fee-for-service entitlement program, because what you are doing is creating a shrinking pot guaranteed to have the Medicare+Choice program implode.

You also talked about the question of pharmaceutical benefits. I was interested we didn't introduce the President's plan because if you look at that, it isn't a very good deal either. It isn't real insurance. It doesn't cover the real concerns in terms of stop-loss, and frankly if you don't, if you don't have better than $500 worth of costs, you ought not to buy that premium going in in the first place because it isn't a cost-effective way of covering yourself.

What we did on the Medicare commission is say that prescription drugs ought to be an integrated part of the Medicare program and they ought to be handled in a particular way. What I find especially frustrating about the Medigap program is that, by law, the first dollar of every Medigap plan has to go for buying down copays and deductibles which produce overutilization in the system. That isn't a very smart way to operate either.

We started the process, we are going to go through with additional changes. But at any point, you will find anomalies in terms of what used to be and where we are trying to go.

Hopefully, as more and more Members grapple with this problem, they are going to have to realize there really isn't a halfway house. We are going to have to accept the changes that need to be made and make them without the politics that have been associated with it in the past, with the understanding that policy delivering benefits to beneficiaries has to be foremost in our decisions.

The gentleman from Maryland.

Mr. CARDIN. I appreciate the comments. And there is not much I disagree with what you said. I agree with you, but today is October 1. Today is the day that HCFA has made its decisions or finished its negotiations with the Medicare+Choice options.

I think there is a difference between what should work in theory and what has happened in reality. I would just be glad to share

with my friend from California what has happened now in Maryland. These are the HMOs that are now available in Maryland. And it is clear that my seniors have less choice. And there are going to be less seniors enrolled in HMOs next year in Maryland than there are enrolled today. And I don't think that is what we intended for Medicare+Choice to do. We expected to have more choice for our seniors.

I look over this list, seniors ask me all the time when I am at senior centers what they can do, I have a hard time recommending any of those plans from the point of view of what I know they are interested in. I appreciate it, but I do think what we did in Medicare+Choice was well intended as far as trying to modify the reimbursement structures for HMOs, but at least in my State this practice hasn't worked.

Chairman THOMAS. And I understand that. I will tell the gentleman I look forward to working with him to try to make some realistic decisions on the short time line that we face. For example, a number of plans began to prepare and make decisions prior to having all the information in front of them. In fact, if we do make an adjustment and it does trickle down, because there is clearly a relationship between what we do on fee for service in the Medicare+Choice, we ought to create an option for people to have another decision as to whether they want to get back in if something happens subsequent to a decision. And it is denying choice if you force them to stay with that decision. Some arbitrary 5-year rule for not getting back into an area when, in fact, the circumstances and the facts have changed in the area, is just punishing people.

But that is what happens when you deal with a bureaucracy. They come up with these mindless decisions that make no sense whatsoever. If in fact the risk adjustment, not withstanding that there might be some slight overpayments, is, in fact, not right—it wasn't created in a day—maybe you need to create a glide slope that stretches out over a longer period of time so you don't have the disruption of the plans available for people. We will get the money. The key is to continue forward and make the changes so that the system works the way it really should.

If what you want are realistic prices and a competitive model in which people get the kind of health care we think they deserve, integrated prescription drugs, you can't do it in some halfway house. Right now we are in a halfway house. And you are seeing the results of that halfway house. I don't think it is acceptable. I think the only direction is to continue to go forward.

The gentlewoman from Florida.

Mrs. THURMAN. One of the things that I think is very concerning to us is that—and probably because there are discussions going on potentially because there could be a BBA fixed bill—is I have folks calling me, screaming about what is happening on HMO or Medicare choice coverage, saying, "You know, everybody is pulling out"—and those kinds of things—and it is your fault. You won't raise the rates on this. You won't give us the same rate of return.

What I was interested in, Dr. Scanlon, and I think this is something that has also got to be talked about because what has happened right next door from Alachua County and Levy County and

then above in the northern part in Colombia County, those—all three of those get almost about the same rate. We have not pulled out of two of those counties, but we have pulled out of one of those counties.

And one of the things that you mentioned in there is lack of providers, that they can, in fact, enroll into this and some other factors. And I think we have to address that, of how do we address that issue; because, quite frankly, the bottom line of all of this is that these are Medicare dollars coming out of the trust fund. And there are seniors in this country that are getting better care and better benefits than those in other parts of the country because they don't have that available to them.

Chairman THOMAS. There is no question—I tell the gentlewoman from Florida, there is no question that is the case. But it has built up over time. Remember any of those additional benefits beyond the basic package guaranteed in law were not designed into the managed care package. Those are the left-over dollars that are available. And when we are squeezing the cost factor, the left-over dollars are fewer, the "benefits are fewer." They are not necessarily intrinsically part of the plan. They are simply the left-over dollars.

And when you take a look at the way in which the formulas are constructed, a significant factor is the way in which health care facilities are utilized in particular areas of the country. It is a simple fact that in certain areas of the country you don't have as much use of health care facilities as in other areas. That is built into the formula.

It seems to me that if people want to use more, they ought to pay more. But that is not the current structure. What we have to do is address the fundamentals. We have not addressed the fundamentals. One of my worries is that arbitrarily and with fixed formula, and with fixed timeframes, we are going to create a system in which 10 years from now there will be no Medicare+Choice because we created a fixed pot of money out of which we remove money—and you heard the Deputy Administrator of HCFA say that they are going to forge ahead with the risk adjuster and it would not be budget neutral—we are going to take money out of this area at a time when the gentleman from Maryland is indicating there are fewer choices available, plans are withdrawing, and that probably doesn't seem to be a really smart decision. Unless of course, these people are committing hari-kari to show us that we are wrong. And that is probably not the case.

I think somewhere there is a reasonable balance over a time line as we bring in additional changes so that we can keep as many plans in place. I think that we might be able to create a bonus payment for people to go into areas, provide a 3- to 5-year bonus payment, because they are not going to go if they lose money. If we create a structure in which they can get to critical mass to be able to stay, a 3- to 5-year assistance so you can have that choice make some sense. Because frankly we are losing a lot of members on any of the changes we are going to go forward with if you get the discrepancies that you get between mostly the urban areas on the coasts and the interior in terms of choice. They are tired of voting for choice and not getting any.

That has got to be one of the areas that we look at as soon as we make some of these adjustments on the Balanced Budget Act. That is one of the reasons I quizzed the Deputy Administrator. I believe they can make a number of administrative decisions which would assist in this area. I am afraid they are not going to, because they are going to force a crisis in the area of managed care so that they can say, "See, we told you it won't work." I hope I am wrong.

Thank you very much. Appreciate you hanging around so that we could get some additional whacks at you.

And we would ask the next panel to come forward. I want to thank you for your patience. I can assure you that your testimony and your presentation are appreciated by this Committee. It will be listened to and we will react. This is a panel of, for want of a better term, providers; but clearly behind each of these providers are significant beneficiaries who receive the particular help that these various organizations represented by these individuals provide.

Beginning on my left, your right, is Sister Carol Keehan, who is president and chief executive officer of Providence Hospital. She will be speaking on behalf of the American Hospital Association. Dr. Richard Corlin, gastroenterologist from Santa Monica, who will be speaking for the American Medical Association. Maribeth Capeloto who will be speaking on behalf of the American Association of Health Plans. Blaine Hendrickson from Rancho Mirage, California, American Health Care Association. Pamela D. Bataillon is from Omaha, Nebraska, the Visiting Nurse Association. And then Nancy B. Swigert, speaking on behalf of the American Speech-Language-Hearing Association.

Each of you have written testimony. You can submit it for the record. And if you would address us in any way you see fit during the time that you have, given the size of the panel, I would be hopeful we will provide lights for you to monitor your oral testimony.

Chairman THOMAS. And, with that, Sister Carol.

STATEMENT OF SISTER CAROL KEEHAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PROVIDENCE HOSPITAL, ON BEHALF OF AMERICAN HOSPITAL ASSOCIATION

Sister KEEHAN. Thank you, Mr. Chairman.

Chairman THOMAS. These microphones are very unidirectional, and you need to speak directly into them. Thank you very much.

Sister KEEHAN. Thank you, Mr. Chairman. I am Sister Carol Keehan, president and CEO of Providence Hospital here in Washington. I am here today representing the American Hospital Association and its 5,000 hospitals and health system members.

I would like to begin by sharing some of the effects the BBA is having on my hospital. Our outside audit firm evaluated the effect of BBA on Providence. For a 5-year period it is $25 million in reduced patient payments. It is not possible to deal with that and deliver the level of care that citizens of metropolitan Washington have associated with Providence since Abraham Lincoln signed our charter. We are not cutting the fat in our system, but literally the muscle, and indeed in some cases the heart of health care.

What is worse, the national impact of the BBA was vastly underestimated. A study by the Lewin Group found that the originally estimated 5-year BBA hospital payment reduction of 53 billion is in reality more in the range of 71 billion, an $18 billion increase. The administration can and must help ease the burdens of BBA.

My written testimony has a list of changes that can be made without legislation. I will briefly outline four.

HCFA should reverse its decision to cut outpatient payments an additional 5.7 percent. This would cost hospitals $900 million each year. HCFA's decision is not consistent with the wishes of Congress, as 77 Senators and 252 Representatives noted in letters to the administration. They wrote that Congress in no way meant for these additional cuts to be made.

HCFA should permanently delay any expansion of the number of DRGs subject to the transfer provision.

HCFA should drop its volume cap on outpatient services.

The BBA requires that HCFA develop methods for controlling unnecessary services, not create a formula-driven mechanism that would penalize hospitals for adopting new technologies and treatments.

Given the fragile condition of Medicare+Choice, implementation of the risk-adjusted payments should be slowed further than the current 5 years. Too fast a pace can cause major disruptions for plans and enrollees.

There are also steps that Congress can take, using the budget surplus to ease the effects of the BBA. Among those outlined in detail in my written testimony are these:

The AHA urges your support for legislation that would provide a payment floor or some kind of stop-loss to protect hospitals from unreasonable losses during the transition to outpatient PPS. It is important that such protection not be done in a budget-neutral manner as additional losses of 3 to 8 percent would be incurred by some hospitals to prevent losses by other hospitals of 20 to 40 percent. New money is needed so that the payments that are already inadequate are not exacerbated.

AHA urges you to repeal the unnecessary and unwarranted transfer provision by adopting H.R. 405, the BBA's skilled nursing facility payments by $9 billion over 5 years. It also required HCFA to implement PPS for these services. But the new PPS fails to adequately account for the differences in the costs of caring for medically complex patients such as ventilator patients. The current payments for these Resource Utilization Groups or RUGs are below the cost of providing the services. Until HCFA can revise the case mix, a multiplier should be used to increase payments for extensive services and special care cases. When the case mix is revised, this additional payment can be used to fund the new format.

Because of their small size, rural hospitals are often unable to absorb the impact of changes in payment and regulatory policies. With the mounting pressures of the BBA, these facilities warrant special consideration. AHA urges relief for rural health care providers, especially sole community providers, critical access hospitals, and Medicare-dependent hospitals.

America's medical schools are often cited as national treasures, yet under the BBA, Medicare's indirect payment for medical edu-

cation is scheduled to be reduced from 7.7 percent to 5.5 percent by fiscal year 2001. This reduction is making it difficult for these institutions to maintain their cutting-edge prominence. AHA urges relief for our Nation's teaching hospitals by freezing the current schedule on further indirect medical education reductions. As I said, details are in my written statement.

Here is the bottom line. Now is the time to repair the unintended consequences of the BBA. We look forward to working with Congress and HCFA to fix the problems I have outlined today. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

[The prepared statement follows:]

Statement of Sister Carol Keehan, President and Chief Executive Officer, Providence Hospital, on behalf of American Hospital Association

Mr. Chairman, I am Sister Carol Keehan, president and CEO of Providence Hospital in Washington, DC. I am here today representing the American Hospital Association (AHA) and its nearly 5,000 hospitals, health systems, networks, and other providers of care. We appreciate this opportunity to present our views on an issue that is dramatically affecting hospitals in communities across America: The Balanced Budget Act of 1997 (BBA).

Our testimony focuses on how relief from the BBA's Medicare spending reductions can be attained through *both* regulatory and legislative means. But first I'd like to share with you some of the effects of the BBA on my hospital, to make clear why immediate relief is so badly needed.

THE BBA'S EFFECT ON PROVIDENCE

I manage a hospital and nursing home in northeast Washington, DC. Our outside audit firm independently evaluated and estimated the effect of the BBA just on Providence Hospital. For a five-year period, it is $25 million in reduced patient payment. It is not possible to deal with that and deliver the level of care that the citizens of metropolitan Washington have come to associate with Providence Hospital since Abraham Lincoln signed our charter.

We are not cutting the fat in our system, but literally the muscle, and indeed in some cases the heart of health care. These deep reductions force choices to cut non-revenue-producing services like palliative care, and much of our patient education program. We also will see our quality evaluation programs and our quality improvement efforts cut, to name only a few areas where there will be an impact.

These actions have real consequences for patients and families. Just ask any family what a good palliative care program has meant to pain control, emotional and spiritual support, as well as basic care for the terminally ill and their families. The list of compromises could go on and on, and we must not allow it. The unintended magnitude of BBA cuts must be addressed because they hurt patients. Even the best-managed hospitals cannot afford them and retain the level of service to patients that is required to meet our mission.

OVERALL EFFECTS OF THE BBA

For over a year, hospitals across the country have been sounding the alarm about problems associated with implementation of the BBA. In all parts of the country—urban as well as rural—we are documenting service closures and cutbacks as hospitals and other health care facilities attempt to wrestle with the BBA's dramatic reductions in Medicare spending.

The BBA mandated the largest changes in Medicare since the program's inception in 1965. In addition, the budgetary impact of these many changes were vastly underestimated. A study conducted by The Lewin Group found that the originally estimated five-year BBA hospital payment reduction of $53 billion is, in reality, more in the range of $71 billion—an $18 billion increase.

Balancing America's budget shouldn't deprive Americans of the health care they need and deserve, and that was clearly not Congress' intent. But that's exactly what's happening across the nation, even though two-thirds of the cuts have yet to take effect. Today's hospitals and health systems encompass all elements of health care delivery affected by the BBA: home health, skilled nursing, outpatient, inpa-

tient, and health plans. This makes the BBA's changes particularly burdensome, and the worst is yet to come.

The Lewin Group was asked by the AHA to forecast the BBA's impact through the year 2002 on payments for hospital services, including inpatient, outpatient, hospital-based home health, rehabilitation, long-term care, psychiatric and cancer services.

Findings from the analysis show:

• For all hospitals, total Medicare margins are projected to be between negative 4.4 percent and negative 7.8 percent in 2002.

• Already in the red when treating Medicare patients, rural hospitals' total Medicare margins may plummet to between negative 7 percent and negative 10.4 percent in 2002 as a result of BBA payment cuts. Urban hospitals' total Medicare margins in three years are predicted to range from negative 3.9 percent to negative 7.3 percent.

• Outpatient service margins also are expected to drop. Medicare outpatient margins—already negative in 1999—are estimated to drop to a negative 28.8 percent if costs increase at a more historical rate of growth; and negative 20.3 percent if hospital costs increase more slowly.

• In just one year, margins for hospital-based home health services are predicted to drop dramatically from negative 4 percent in year 2000, to negative 11.6 percent in 2001. Fifty percent of hospitals now provide home health care.

Mr. Chairman, caregivers won't compromise quality. But they simply can't afford to continue providing services if their costs aren't even covered. How are they to survive? Communities already are losing access to vital health care services as Washington debates how to spend a federal budget surplus of billions of dollars. Hospitals are being forced to cut back or shut down services that affect not just the elderly who rely on Medicare, but all patients. When the government acted to reduce Medicare spending to help balance the budget, no one was certain what effect such enormous reductions would have. Now we know.

It is critical that Congress and the Administration act now to alleviate these unintended consequences of the BBA. Here are the administrative and legislative solutions that we believe can ease the unintended consequences of the BBA.

Regulatory Solutions

In implementing parts of the BBA, the Health Care Financing Administration (HCFA) has, in some cases, interpreted the law in ways that we believe are contrary to congressional intent. There are several steps that HCFA can and must take to remedy this—and by doing so, these solutions can be achieved without the need for legislation.

Outpatient PPS—One especially troubling area on the regulatory front for hospitals and health systems is HCFA's implementation of outpatient PPS. There are several concerns we have with the direction in which the agency seems to be headed.

Once the new outpatient PPS system is implemented, HCFA plans to reduce hospital outpatient payments by an additional 5.7 percent to fund lower beneficiary outpatient copayments. This means that, on top of the $9 billion in five-year outpatient payment cuts already in the BBA, hospitals would suffer further cuts of $900 million annually. This is contrary to the wishes of more than 252 members of the House and 77 members of the Senate, who signed recent letters to HCFA opposing this arbitrary, unfair, and uncalled for cut. They made it clear that Congress, in passing the BBA, in no way meant for additional spending cuts to be made to hospital outpatient payments beyond the PPS.

According to the congressional letters, HCFA's decision is "inconsistent with Congress' intent," and would be "inappropriate and unwise." In fact, when the BBA was being drafted, Congress, beneficiaries, hospitals and the Administration agreed that beneficiary coinsurance needed to be reduced, but that there would be no additional hospital payment reductions as a result. HCFA's interpretation of the BBA is inconsistent with that agreement, and with the law itself.

The AHA believes that HCFA has the flexibility to interpret the law correctly, so that the proposed payment system does not extract another $900 million from hospitals.

Provider-based outpatient facilities—Hospitals are no longer just buildings with four walls. Today, more than ever, advances in science and technology have allowed hospitals to reach out into their communities to bring care where it is needed. This is especially true of outpatient services. In community after community across America, hospitals are working with others to deliver care where it is needed.

Unfortunately, HCFA threatens the existence of this important care by adding too-narrow requirements for determining what entities can be considered hospital outpatient departments. requirement for state licensure in the proposed rule is arbitrarily biased against providers in states where licensure does not even exist to cover off-campus facilities. Moreover, the proposed requirement that Medicare should mirror how other payers view these facilities is one-sided, ignoring contractual arrangements between hospitals and private insurers that offset the lack of a facility fee. These requirements would discourage hospitals and health systems from reaching out and bringing high-quality health care to underserved areas of their communities. We urge HCFA to use conditions of participation or accreditation where licensure is not available, and we urge the agency to significantly revise its too-narrow proposed requirements governing provider-based facilities.

Volume cap—HCFA proposes to reduce future payment updates if Medicare payments for hospital outpatient services exceed the agency's projections. If this proposal is implemented, hospitals would be penalized for adopting new technologies and treatments that increase the volume of outpatient services while also enhancing the lives and comfort of beneficiaries.

The BBA requires that HCFA develop methods for controlling *unnecessary* services. Volume targets do not make this distinction and do not fulfill the statutory requirement to probe beyond the numbers. Moreover, physicians order services, not hospitals. As a result, HCFA's formula-driven targets would penalize all providers.

Looking at unnecessary services requires HCFA to develop coverage criteria, monitor for medical necessity and reject claims where services are medically unnecessary. Peer review organizations (PROs) can review practice patterns and identify aberrant practices and practices of questionable medical utility.

The President's Medicare reform proposal indicates that the administration is considering delaying implementation of this proposal. While we commend the administration for this delay, a delay of a bad policy is not sufficient. We strongly urge HCFA to exercise its option under the BBA to drop this provision altogether. Doing so will ensure that beneficiaries have continued access to new treatments and technologies in the outpatient setting.

Accuracy of data—We are extremely concerned about the data with which HCFA is calculating its payment rates under outpatient PPS. For example, HCFA estimated that Henry Ford Health System in Detroit would see an increase of almost $1 million in outpatient payments under PPS. However, Henry Ford's own analysis identified several discrepancies in HCFA's estimates. In fact, Henry Ford calculated that the system will actually see a decrease in payments of $9.6 million, or 21 percent of their total outpatient revenue. If a system like theirs, which was expected to see a slight increase in payments, actually experiences a 21 percent reduction, what will happen to those many hospitals projected to experience a 30 percent loss?

The BBA requires that HCFA use a reliable payment methodology. The margin of error clearly indicates HCFA's proposal does not meet this requirement. This is a key reason why a payment "floor" is needed, such as Rep. Foley's bill (H.R. 2241). A floor would protect hospitals from catastrophic losses if rates are set too low while HCFA makes the coding/reporting changes needed to ensure that accurate information is used to project the effects of outpatient PPS. At the same time, the floor would protect the government from too-high rates set for the same reason.

In the President's Medicare reform proposal, the large losses created by the outpatient PPS are addressed through a budget neutral transition for groups of specified hospitals. The AHA does not support a budget neutral transition. Budget neutrality would actually increase losses of some hospitals during the transition to outpatient PPS. Money must be added so that the BBA's current underfunding of the system is not exacerbated.

Therapy bad debt payments—We are concerned that HCFA may be interpreting the BBA in a too-narrow manner on the issue of payment for occupational, speech and physical therapy. Specifically, hospitals are currently reimbursed for the bad debt they incur when a beneficiary receiving such therapy cannot pay the coinsurance. Typically, these beneficiaries do not qualify for Medicaid but cannot afford Medigap coverage. However, in the implementation of the therapy fee schedule, HCFA has indicated that it may no longer reimburse hospitals for this bad debt. We strongly urge HCFA to retain the ability of hospitals to be reimbursed for therapy services provided to those elderly who cannot pay.

Chemotherapy—The AHA believes that there are serious problems with the data HCFA is using to determine payment for chemotherapy services. For example, HCFA had to remove the most representative data—claims with multiple services that use multiple drugs in a single session—because the costs are not separable. Since chemotherapy treatments generally involve the administration of multiple

drugs, elimination of claims with multiple sessions and multiple drugs would appear to leave only claims that do not portray a true clinical picture of chemotherapy.

As a transitional payment methodology, the AHA recommends that HCFA temporarily carve out the costs for chemotherapy and chemotherapeutic agents and pay on a reasonable cost basis until the agency fixes the underlying coding problems, collects new data, and proposes new groups or rates. The results would then be included in a subsequent proposed rule. Otherwise, hospitals may be forced to close their cancer centers rather than provide lower quality or inappropriate care.

In addition, HCFA's proposal to classify new agents in the lowest cost group does not reflect what we expect in the future for drug costs. According to the Bureau of Economic Analysis and other sources, most of the new drugs—especially new genetically engineered drugs—are more costly than prior drugs. Clearly, this proposal would penalize hospitals for using new pharmaceuticals. Moreover, it is incumbent on the agency to get the information it needs on drug prices to ensure that it can classify new drugs, or any new technology, into the most appropriate group from the standpoint of both clinical coherence and resource use. The AHA opposes HCFA's proposal to place new agents in the lowest payment group. Similarly, HCFA should evaluate how to pay for new technology in a timely and fair manner.

We therefore urge HCFA through regulation to develop and propose methodologies to better recognize the costs of new technology. However, new and expensive drugs and technologies should not be paid separately from PPS, and we would oppose any legislation that would do so. Among other problems, paying these costs separately might lead to double counting of drug costs if some of the high-cost drugs were substitutes for lower-cost drugs.

Medicare+Choice—HCFA estimates that, during the 5-year implementation of risk-adjusted Medicare+Choice rates, payments will stay the same or decrease for 95 percent of plans in the program, and increase for 5 percent of plans. Because so many more plans will receive less money, Medicare will accrue savings of more than $11 billion.

Given the fragile condition of Medicare+Choice, we believe implementation of risk-adjusted payment rates should be slowed even further than five years. Too fast a pace could cause major disruptions for plans and their enrollees. While a slower pace is necessary for most plans, HCFA should also have a means to more quickly recognize the higher costs of that 5 percent of plans who are serving higher-risk populations during this implementation period.

In addition, the government must solve the practical problems that will ultimately determine the success of Medicare+Choice. For example, while we have recommended to Congress that it fund a blend of national and county rates to make Medicare managed care rates more equal across the country, during 1998 and 1999 these plans did not receive a blended rate, due to the way the BBA handles updates and budget neutrality adjustments. We urge HCFA to make recommendations to Congress on how to create more equitable updates between private market and Medicare+Choice plans across the country.

HCFA also needs to look at ways to reduce administrative burden. Medicare+Choice plans must fund their administrative costs from their capitation rates. Any increase in administrative costs will reduce the dollars available for patient care. An example is NODMAR, the Notice of Discharge and Medicare Appeal Rights. This notice used to be given only to those beneficiaries who object to going home, but hospitals are now required to give it to all patients. This is unnecessary and costly, since general appeal rights notices are already provided at admission.

Transfers—Medicare patients sent from one acute care hospital to another are defined as transfers. Under the BBA, HCFA defines transfers to include cases where a patient in one of 10 diagnosis-related groups (DRG) chosen by HCFA stays in the hospital at least one day less than the national average and then is sent to one of several post-acute care settings. In the past, hospitals received the full Medicare DRG payment for each discharge under PPS, regardless of the patient's length of stay. Payments for cases shorter than average stays help defray the costs of caring for patients with longer-than-average stays. This rule of averaging is one of the fundamental principles upon which PPS was built.

We appreciate the Administration's willingness to delay any expansion of the transfer provision beyond the current 10 DRGs for two years. However, we believe it must be delayed permanently, and we urge the administration to do so. While we will continue to urge Congress to repeal the provision legislatively (see below), the administration should, at a minimum, not expand this onerous and unfair provision.

Legislative Solutions

In addition to changes that the administration can make to alleviate the unintended consequences of the BBA, there are several legislative steps that we urge Congress to take as well. Together, they make up a legislative package that can bring real relief to the nation's hospitals and the communities they serve. urge Congress to enact the following initiatives, funded through the budget surplus. These initiatives represent a broad-based relief effort—an effort that would provide effective relief not just for hospitals, but for a variety of health care providers who take care of Medicare beneficiaries in several different settings.

Outpatient—According to a recent MedPAC report, Medicare reimbursed hospitals only 90 cents for each dollar of outpatient care provided prior to enactment of the BBA. Today, as a result of the BBA, hospitals are paid only 82 cents on the dollar. And after PPS is implemented, HCFA will reduce hospital outpatient payments by another 5.7 percent. However, according to HCFA's own estimates, many hospitals will lose much more than just that 5.7 percent. Because of the huge redistributional effects of PPS, more than half of the nation's major teaching hospitals would lose more than 10 percent; nearly half of rural hospitals also would more than 10 percent.

In addition, catastrophic losses would be experienced by some individual hospitals. For example, large hospitals in Iowa and New Hampshire will immediately lose almost 14 to 15 percent of their Medicare outpatient revenue. Other large urban hospitals in Missouri, Massachusetts, Wisconsin, Florida, and California stand to lose 20 percent to 40 percent. Some New York City hospitals would lose more than 40 percent. Some small rural hospitals in Arkansas, Kansas, Mississippi, Washington, and Texas will lose more than 50 percent of their revenue.

To prevent these precipitous drops in Medicare revenues from doing additional harm to hospitals and the Medicare beneficiaries who rely on them, we urge passage of legislation that would limit payment losses created by the move to outpatient PPS. However, the costs of financing this proposal should *not* be paid by the remaining hospitals, because most of them are also expected to lose under the outpatient PPS. Additional losses would have to be incurred by those hospitals, ranging from 3 to 8 percent, to protect other hospitals from losses of 5 to 15 percent. Instead, this change needs to be funded by additional Medicare spending. Beneficiary spending would be unaffected. Under this proposal, until January 2002, each hospital's Medicare payments for outpatient PPS services would be adjusted so that the hospital's losses are limited to 5 percent of what the hospital would have been paid by Medicare under the current system. For calendar year 2002, the payment losses would be limited to 10 percent. For CY 2003, the payment losses would be limited to 15 percent. No limit is set after 2003. Depending on whether HCFA changes its interpretation that unfairly cuts an additional 5.7 percent from hospitals under outpatient PPS, this proposal will require roughly $1.9 billion over five years in new funding. The AHA urges your support for legislation that would provide such a payment "floor" and protect hospitals from unreasonable losses during the transition to outpatient PPS. *Such legislation (H.R. 2241) was introduced in June by Rep. Mark Foley (R–FL), and has 78 co-sponsors. We urge you to support it.*

Transfer policy—As mentioned above, we believe HCFA has the administrative capability to delay permanently the expansion of DRGs affected by this provision. However, a legislative solution to repeal this provision does exist. *AHA urges you to repeal the unnecessary and unwarranted transfer provision by adopting H.R. 405.*

Inpatient—The Medicare Payment Advisory Commission (MedPAC) has reported that hospitals will "incur significant operating and capital costs in becoming year 2000 compliant." As a result, MedPAC has recommended that a modest increase in hospital inpatient payments be made to help offset the costs of these improvements to medical devices and information systems. *AHA urges adoption of MedPAC's recommendation for a modest PPS update to compensate hospitals for Y2K readiness activities, through the passage of H.R. 2266.*

Rural relief—Because of their small size, rural hospitals are often unable to absorb the impact of changes in payment and regulatory policies. With the mounting pressures of the BBA, these facilities warrant special consideration, especially considering their role as the hub of the local health care delivery system. *AHA urges relief for rural health care providers—particularly sole community providers, critical access hospitals, and Medicare-dependent hospitals—through the adoption of some of the provisions of H.R. 1344.*

Medical education—This nation's medical schools are often referred to as national treasures. Yet under the BBA, Medicare's indirect payment for medical education is scheduled to be reduced from 7.7 percent to 5.5 percent by FY 2001. We all benefit from the research and medical education conducted in our medical schools and

teaching hospitals, but this reduction is making it difficult for these institutions to maintain their cutting-edge prominence. *AHA urges relief for our nation's teaching hospitals by freezing the current schedule on further indirect medical education reductions through the adoption of H.R. 1785.*

Disproportionate share payments—The BBA took an important step by removing hospitals' clinical education payments from Medicare+Choice payments. This move was made to ensure that payments be made to those facilities actually incurring the added costs. Unfortunately, BBA did not remove disproportionate share (DSH) payment. This special payment is made to support the additional costs hospitals incur in treating large numbers of low-income individuals. Without this funding, these institutions will experience difficulty maintaining access to vital health care services for low-income individuals. *AHA urges relief for hospitals serving the uninsured by adopting H.R. 1103, which carves out disproportionate share payments from Medicare managed care payments.*

Managed care—The BBA set in motion a long-overdue change to the Medicare program by reducing geographic variations in managed care payments. This equity update to Medicare+Choice payments would be accomplished by "blending" the county rate with a national rate, thus reducing the historic variation in Medicare health plan payments from county to county throughout the country. HCFA has had difficulty fully implementing this provision due to the way the law was drafted. *AHA urges the full funding of the Medicare managed care payment blend to provide fair payment in all parts of the country by adopting H.R. 406.*

Long-term care—The BBA reduced skilled nursing facility (SNF) payments by $9 billion over five years. At the same time, it required HCFA to implement a prospective payment system for these services. The new PPS is not refined enough, however, and therefore fails to adequately account for differences in costs associated with the care of medically complex patients. In particular, the payment for non-therapy ancillaries (pharmaceuticals, respiratory therapy and special equipment) is the same proportion across all the categories in the payment system, even though for some patients care costs are much higher.

Both HCFA and providers believe these issues can ultimately be addressed by revising current case-mix categories (Resource Utilization Groups) used in the new SNF PPS to reflect these types of patients. However, HCFA cannot make any changes to case-mix until after 2000, and additional dollars are still needed to mitigate the consequences of the BBA. HCFA has also not completed its research on how to improve case-mix. Based on preliminary research by HCFA contractors, patients in two RUGs categories "extensive services," which includes patients who need IV feeding, IV medications, or require ventilators, and "special care," which includes patients who have multiple sclerosis, cerebral palsy or require respiratory therapy seven days a week—have much higher non-therapy ancillary costs than other patients. The current payments for these RUGs are far below the costs of providing the services, ranging from a high of 81 percent to a low of 62 percent of costs.

A multiplier should be used to increase the payments for these groups extensive services and special care until the final case-mix improvements can be made by HCFA. The specific multiplier will no longer be necessary once the Secretary refines case-mix and the funding can then be used to fund the revised case-mix format. The multiplier can be implemented regardless of the Y2K restrictions since HCFA already plans on updating the RUG rates in October 1999.

Psychiatric PPS—Cuts to psychiatric services were also included in the BBA. As a result, many hospitals serving the mentally ill will receive payments below previous levels—real cuts. *AHA urges adjustments to payments to psychiatric hospitals in a budget-neutral manner by adopting H.R. 1006.*

Home Health—BBA included a number of changes in payment, coverage, and administrative requirements for home health agencies. Until PPS could be implemented, BBA provided for an interim payment system (IPS) designed to reduce payments to home health agencies. The IPS was the first of the BBA's provisions to be implemented and created a number of disruptions in access to services in some areas of the country. *AHA urges that additional funding be targeted to home health providers to minimize the ongoing inequities of the IPS, and lessen the 15 percent payment cut scheduled for the home health PPS in FY 2001.*

Conclusion

Now is the time to repair the damage done by the BBA. We strongly urge you to act now, before you recess for this year, on these BBA relief measures. With a new century dawning, we must work together to ensure that the Americans we serve can achieve hospitals' vision of a healtheir America. We look forward to work-

ing with Congress and HCFA to fix the problems that we have outlined for you today.

Chairman THOMAS. Dr. Corlin.

STATEMENT OF RICHARD F. CORLIN, M.D., GASTROENTEROLOGIST, SANTA MONICA, CALIFORNIA, AND SPEAKER, AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Dr. CORLIN. Thank you, Mr. Chairman. My name is Richard Corlin. I am a gastroenterologist in private practice in Santa Monica, California. And I also serve as speaker of the AMA's House of Delegates.

Mr. Chairman, we particularly appreciate your efforts to reform the Medicare program and look forward to working with you and each Member of this Subcommittee on comprehensive reform. Today, however, we ask the Subcommittee to focus on fixing the serious problems with Medicare sustainable growth rate system, the SGR.

Mr. Chairman, we request that you direct HCFA to correct the $3 billion projection errors in the 1998 and 1999 SGR. We further request that you approve legislation this year to improve the SGR system. The SGR enacted under the BBA of 1997 is intended to slow the projected rate of growth of physician services. It is calculated each year with a base level and then growth based on four factors: medical inflation, changes in Medicare fee-for-service enrollment, GDP growth per cap, and changes in spending due to law and regulations.

MedPAC has recommended a series of improvements much of which Dr. Wilensky has underscored earlier today. Some of these are: (1) to require HCFA to correct its projection errors and restore the $3 billion SGR shortfall resulting from these errors—money that was intended to be there as part of the BBA; (2) to increase the SGR target to account for physician costs due to technological advances and an aging population; (3) to implement measures to curtail volatility in physician payment rates; and (4) require HCFA and MedPAC to provide information and data on payment updates.

SGR projection errors are inevitable, since HCFA must use estimates to calculate the SGR at the beginning of each year. Thus, physician payment updates are not based on actual data but on projected data which has so far proven erroneous; and, worse than that, which HCFA refuses to correct.

For the 1999 SGR, HCFA projected that Medicare-managed care enrollment would rise 29 percent. It actually increased only 11 percent. This error led to a corresponding drop in projected fee-for-service enrollment and a negative 1999 SGR. As a result of this error, physicians are caring for more than 1 million patients, more in Medicare fee-for-service than are either accounted for or paid for at all by HCFA.

For the 2000 SGR which is published in this morning's Federal Register, HCFA has projected Medicare-managed care enrollments again which are growing at a rate far steeper than that projected by the CBO. Although HCFA does not believe it has the legislative

authority to correct its own projection errors, we strongly disagree. The AMA's Office of General Counsel has reviewed this matter and has advised that the statute, and its legislative history as well as long established rules of statutory construction, firmly store the view that HCFA can and must direct its own SGR projection errors.

On October 27, 1997, the final notice signed by Nancy DeParle and Donna Shalala stated, "Differences between projected and actual enrollment will be adjusted for in subsequent years." and again, "Differences between actual and real gross domestic product per capita growth will be adjusted for in subsequent years.".

In addition, the SGR needs to be set at a GDP plus at least 2 percentage points to take into account the two main factors responsible for increasing health care costs: advances in technology and aging population. And again, we need to make HCFA live up to its own commitment in adjusting estimated costs for real costs once the data is available.

MedPAC has recommended that the SGR include a factor higher than GDP to account for, "cost increases due to improvements in medical capabilities and advancements in scientific technology." We strongly agree with that as well.

Physicians, regardless of our speciality, are unanimous in our concern that payment cuts due to flaws in the SGR on top of more than a decade of previous cuts could threaten our ability to continue to offer our Medicare patients the finest medical care in the world. Thus the SGR system must be fixed and it must be fixed this year. Thank you.

Mr. MCCRERY [presiding]. Thank you, Dr. Corlin.

[The prepared statement follows:]

Statement of Richard F. Corlin, M.D., Gastroenterologist, Santa Monica, California and Speaker, House of Delegates, American Medical Association

The American Medical Association (AMA) appreciates the opportunity to present to this Subcommittee our views concerning improvements to the Medicare sustainable growth rate (SGR) system for physicians' services, and appreciates the Subcommittee's focus on this important issue. As Congress prepares to consider Balanced Budget Act (BBA) refinements and Medicare reforms, the AMA urges inclusion of improvements in Medicare's SGR system in any legislation approved by the Subcommittee, and urges the Subcommittee to request that HCFA immediately correct its 1998 and 1999 SGR projection errors.

The SGR, enacted under the BBA, establishes a target growth rate for Medicare spending on physician services and is intended to slow the projected rate of growth in Medicare expenditures for physicians' services. Annual adjustments to physician payment rates are up or down, depending on whether actual spending on physician services is below or above the SGR target.

Physicians are the only group subject to the SGR target, despite the fact that Medicare spending on physician services has been growing more slowly than other Medicare benefits. Although the BBA included measures to slow projected growth in these other benefits, the Congressional Budget Office continues to forecast much higher average annual growth rates for other services than for physician services over the next decade. In contrast to annual growth in outlays of 4.6 percent for inpatient hospital services, 5.7 percent for skilled nursing facilities, 6.5 percent for home health, and 14.6 percent for Medicare+Choice plans, average annual growth in physician services is projected at only 3.1 percent from 2000–2009.

Physicians were subject to significant and disproportionate Medicare payment cuts prior to the BBA, yet we have never abandoned our elderly and disabled patients. From 1991–97, physician payment updates already had slipped 10 percent below growth in medical practice costs.

The physician community is concerned that the growth limits in the current SGR system are so stringent that they will have a chilling effect on the adoption and dif-

fusion of innovations in medical practice and new medical technologies. In addition, we are concerned that the Health Care Financing Administration (HCFA) has not revised its projections used in establishing the 1998 SGR when data proved HCFA erroneous. Further, HCFA has stated it will not correct 1999 SGR errors without a congressional mandate, despite that in the first two years of the SGR, erroneous HCFA estimates have already shortchanged the target by more than $3 billion. Finally, we are concerned that the SGR could also cause future payments to be highly volatile and fall well behind inflation in practice costs.

Medicare Physician Payments and Medicare Payment Advisory Commission Recommendations

Medicare payments for physicians' services are updated annually by HCFA. Payment rates are based on a relative value scale system, enacted under OBRA 89, that reflects the physician work, practice expense and professional liability insurance costs involved in each service. The relative value for each service is multiplied by a dollar conversion factor to establish actual payment amounts. The conversion factor is required to be updated each calendar year, which involves, in part, establishing an update adjustment factor that is adjusted annually by the SGR.

In its March 1999 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) identified serious problems in the SGR system and recommended significant improvements to it. The AMA and the national medical specialty societies share MedPAC's concerns and believe that improving the SGR is a critical component of efforts to ensure that the 85 percent of Medicare beneficiaries who are enrolled in the fee-for-service program continue to receive the benefits to which they are entitled.

MedPAC recommends, and the AMA agrees, that Congress revise the SGR system as follows:

- The SGR should include a factor of growth in real gross domestic product per capita plus an allowance for cost increases due to improvements in medical capabilities and advancements in scientific technology;
- The Secretary should be required to publish an estimate of conversion factor updates by March 31 of the year before their implementation;
- The time lags between SGR measurement periods should be reduced by allowing calculation of the SGR and update adjustment factors on a calendar year basis;
- HCFA should be required to correct the estimates used in the SGR calculations every year; and
- The SGR should reflect changes in the composition of Medicare fee-for-service enrollment.

The Sustainable Growth Rate System

The SGR system was enacted under the BBA and replaces the Medicare Volume Performance Standard system, which had been the basis for setting Medicare conversion factor updates since 1992. The SGR sets a target rate of spending growth based on four factors: changes in payments for physician services before legislative adjustments (essentially inflation); changes in Medicare fee-for-service enrollment; changes in real per capita gross domestic product (GDP); and an allowance for legislative and regulatory factors affecting physician expenditures. Growth in real per capita GDP represents the formula's allowance for growth in the utilization of physician services.

The target rate of spending growth is calculated each year and is designed to hold annual growth in utilization of services per beneficiary to the same level as annual GDP. Physician payment updates depend on whether utilization growth exceeds or falls short of the target rate. If utilization growth exceeds GDP, then payment updates are less than inflation. If utilization is less than GDP, payment updates are above inflation.

Because of the serious problems with the SGR system, as discussed below, four improvements must be included in legislation to fix the SGR:

- There must be a requirement to correct HCFA's projection errors and restore the $3 billion SGR shortfall resulting from these errors;
- The SGR must be increased to account for physician costs due to adoption of new technology;
- Measures must be implemented to curtail volatility in physician payment rates and avoid steep cuts in the future; and
- HCFA and MedPAC must be required to provide information and data on payment updates.

PROBLEMS WITH THE SUSTAINABLE GROWTH RATE SYSTEM

Of the needed improvements listed above, we wish to focus on two major problems with the SGR. First, there is a "projection error" problem. Specifically, in determining the SGR each year, HCFA must estimate certain factors used to calculate the SGR. In the first two years of the SGR system, HCFA has seriously miscalculated these factors, and thus physicians have been shortchanged by several billion dollars. In addition, these projection errors will continue each year, and the resulting shortfalls will be compounded.

The second major problem with the SGR system is that it does not allow growth in physician payments sufficient to account for physicians' costs due to technological innovations. In addition, as discussed above, there are other problems with the SGR system, which we have separately addressed below.

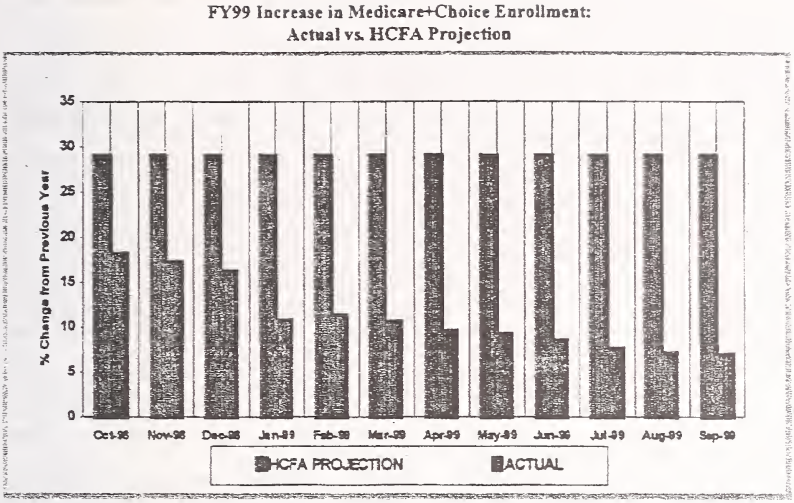
Finally, we note that, unlike some other Medicare payment issues, the problems with the SGR system and their solutions are a matter on which the physician community is unified. National organizations, regardless of medical specialty, as well as organizations representing medical colleges and group practices, have been working closely together with the AMA to address these complex issues. On behalf of the entire physician community, we ask Congress to take the necessary steps to assure that we can continue to offer our Medicare patients the finest medical care in the world.

The Projection Error Problem

HCFA's SGR Projection Errors Must Be Corrected. Two of the four factors used to calculate the SGR target each year are growth in U.S. GDP and Medicare fee-for-service enrollment growth. Because the target must be calculated before the year begins, HCFA can only speculate as to what GDP growth will be and how many people will enroll in fee-for-service versus managed care. Recognizing the need for such speculation, HCFA acknowledged in a 1997 physician rate update regulatory notice that the actual data for each year, once available, might reveal errors in its estimates of as much as 1 percent, or $400 million. HCFA also promised that the difference between its projections and actual data would be corrected in future years.

In the first two years of the SGR, erroneous HCFA estimates have already shortchanged physician payments by more than $3 billion. Specifically, the 1998 SGR projection error was $700 million, and the 1999 SGR error was $2.5 billion. HCFA has not corrected these projection errors and does not plan to do so, without further legislative authority. One year after the 1997 notice, HCFA reneged on its pledge to correct SGR errors based on its newly-conceived assertion that the agency does not believe it has the proper legislative authority to correct such errors. (See below discussion of our strong belief that HCFA absolutely has the authority to correct its own projection errors.) HCFA then simultaneously issued its most egregious error by projecting Medicare managed care enrollment would rise 29 percent in 1999, despite the many HMOs abandoning Medicare in 1999. This error led, in turn, to a projected drop in fee-for-service enrollment and a *negative* 1999 SGR. Data now show that managed care enrollment has increased only 11 percent, a fraction of HCFA's projection, which means *physicians are caring for 1 million more patients in Medicare fee-for-service than were forecast.*

The table below shows the magnitude of the errors that HCFA has made to date in its estimates of GDP and enrollment growth:



The 1998 and 1999 SGR projection errors are a serious problem. The SGR is a cumulative (as opposed to annual) system, and the cumulative SGR target is like a savings account for physician services. As discussed, HCFA's errors have left a $3 billion shortfall in this account, which, if not restored, will either produce unwarranted payment cuts or deficient payment increases. Indeed, the 1999 SGR projection error alone will increase to $5 billion by the end of the year 2000 if left uncorrected. Although the President's 2000 budget proposes to address the projection errors, we are concerned that HCFA may correct the errors in a way that will effectively cancel any benefit to payment rates from using accurate data.

Physicians have faced a decade of payment cuts without ever abandoning Medicare patients. We have done our part to keep costs within the limits imposed by the BBA. Now, Congress must do its part by insisting that payment updates be based on correct SGR estimates.

HCFA Has The Legislative Authority to Correct Its SGR Projection Errors. As discussed above, HCFA presently is adopting the stance that it lacks the legislative authority to make annual corrections to SGR projection errors, yet we have never heard a clear explanation from HCFA as to the basis for its position.

It would be an understatement to say that we strenuously disagree with HCFA's position. From our perspective, HCFA's professed lack of legislative authority is disingenuous—it flies in the face of clear legislative intent and well-established principles of statutory construction, not to mention common sense. Application of a statute by a regulatory agency certainly allows for reasonable interpretation.

In adopting the SGR system, Congress replaced one Medicare physician payment update system with one that was thought to be improved. It would be ludicrous to construe the statute, as HCFA apparently now professes to do, to indicate that Congress intended the SGR to be a system based exclusively and perpetually on estimates, without any mechanism to tie physician payments to real data. The statute does not say this, and legislative intent does not support this.

This logical construction of the statutory language is bolstered by the legislative history and HCFA's own prior regulatory acknowledgments of the propriety of these periodic reconciliations. Congress adopted the SGR language in response to PPRC recommendations contained in its 1996 Report to Congress. This report clearly indicated that annual reconciliations should occur in order to mitigate the effects of projection errors. Moreover, HCFA itself has previously acknowledged in a 1997 regulatory notice that it would conduct reconciliations to correct SGR projection errors in future years.

In short, the statute itself, and the clear legislative intent provide that HCFA has the statutory authority to implement annual reconciliations. In fact, we believe HCFA has the responsibility to exercise its rulemaking authority to carry out this legislative intent.

The SGR Must Allow for Technological Innovations and Other Factors Impacting Utilization of Health Care Services

MedPAC has also recommended that Congress revise the SGR to include a factor of growth in real gross domestic product per capita plus an allowance for cost increases due to improvements in medical capabilities and advancements in scientific technology. The system is currently designed to hold annual utilization growth at or below annual GDP growth. A common method for policymakers to evaluate trends in national health expenditures is to look at growth in health spending as a percentage of GDP, but this approach is replete with problems. There is no true relationship between GDP growth and health care needs. Forecasts by Congressional Budget Office and the U.S. Census Bureau indicate that real per capita GDP growth will average about 1.5 percent per year over the next decade. This is far below historical rates of Medicare utilization growth. Indeed, at 5.9 percent, average annual per beneficiary growth in utilization of physicians' services was three to four times higher than GDP growth from 1981–1996. Thus, if history is any guide, holding utilization growth to the level of GDP growth virtually guarantees that Medicare physician payments will decline.

A primary reason for this lack of congruity between GDP and Medicare utilization is that GDP does not take into account health status trends nor site-of-service changes. Thus, if there were an economic downturn with negative GDP growth at the same time that a serious health threat struck a large proportion of Medicare beneficiaries, the consequences could be disastrous.

Secondly, GDP does not take into account technological innovations. The only way for technological innovations in medical care to really take root and improve standards of care is for physicians to invest in those technologies and incorporate them into their regular clinical practice. The invention of a new medical device cannot, in and of itself, improve health care—physicians must take the time to learn about the equipment, practice using it, train their staff, integrate it into their diagnosis and treatment plans and invest significant capital in it. Yet physician spending is the only sector of Medicare that is held to as stringent a growth standard as GDP and that faces a real possibility of payment cuts of as much as 5 percent each year. Keeping utilization growth at GDP growth will hold total spending growth for physician services well below that of the total Medicare program and other service providers.

To address this problem, as recommended by MedPAC, the factor of growth under the SGR relating to GDP must be adjusted to allow for innovation in medical technology. We believe that to implement adequately MedPAC's recommendation, the SGR should be set at GDP+2 percentage points to take into account technological innovation, as discussed further below.

In addition, we urge that Congress consider a long-term approach to setting an appropriate growth target that takes into account site-of-service changes, as well as health status and other differences between Medicare's fee-for-service and managed care populations that lead to differential utilization growth. Thus, we believe that the Agency for Health Care Policy and Research (AHCPR) should be directed to analyze and provide a report to MedPAC on one or more methods for accurately estimating the economic impact on Medicare expenditures for physician services resulting from improvements in medical capabilities and advancements in scientific technology, changes in the composition of enrollment of beneficiaries under the fee-for-service Medicare program and shifts in usage of sites-of-service.

Technological Innovation. Congress has demonstrated its interest in fostering advances in medical technology and making these advances available to Medicare beneficiaries through FDA modernization, increases in the National Institutes of Health budget, and efforts to improve Medicare's coverage policy decision process. The benefits of these efforts could be seriously undermined if physicians face disincentives to invest in new medical technologies as a result of inadequate expenditure targets.

As first envisioned by the PPRC, the SGR included a 1 to 2 percentage point add-on to GDP for changes in medical technology. Ever-improving diagnostic tools such as magnetic resonance imaging, new surgical techniques including laparoscopy and other minimally-invasive approaches, and new medical treatments have undoubtedly contributed to growth in utilization of physician services and the well-being of Medicare beneficiaries. For example, a recent paper published by the National Academy of Sciences indicated that from 1982–1994 the rates of chronic disability among the elderly declined 1.5 percent annually.

With GDP projected to grow by 1.5 percent annually, the failure to allow an additional 1 to 2 percentage points to the SGR for technological innovation means that the utilization target is only half the rate that was originally planned. Technological

change in medicine shows no sign of abating, and the SGR should include a technology add-on to assure Medicare beneficiaries continued access to mainstream, state-of-the art quality medical care.

Site-of-Service Shifts. Another concern that should be taken into account by the GDP growth factor is the effect of the shift in care from hospital inpatient settings to outpatient sites. As MedPAC has pointed out, hospitals have reduced the cost of inpatient care by reducing lengths-of-stay and staff and moving more services to outpatient sites, including physician offices. These declines in inpatient costs, however, are partially offset by increased costs in physician offices. Thus, an add-on to the SGR target is needed to allow for this trend.

Beneficiary Characteristics. The SGR should also be adjusted for changes over time in the characteristics of patients enrolling the fee-for-service program. A MedPAC analysis has shown that the fee-for-service population is older, with proportions in the oldest age groups (aged 75 to 84 and those age 85 and over) increasing, while proportions in the younger age group (aged 65–74) has decreased as a percent of total fee-for-service enrollment. Older beneficiaries likely require increased health care services, and in fact MedPAC reported a correlation between the foregoing change in composition of fee-for-service enrollment and increased spending on physician services. If those requiring a greater intensity of service remain in fee-for-service, the SGR utilization standard should be adjusted accordingly.

Other Problems with the SGR System

Stabilizing Payment Updates under the SGR System. The AMA strongly agrees with MedPAC's further recommendation that Congress should stabilize the SGR system by calculating the SGR and the update adjustment factor on a calendar year basis.

Instability in annual payment updates to physicians is another serious problem under the SGR system, as has been acknowledged by HCFA. Projections by the AMA, MedPAC and HCFA show the SGR formula producing alternating periods of maximum and minimum payment updates, from inflation plus 3 percent to inflation minus 7 percent. Assuming a constant inflation rate, these alternating periods could produce payment decreases of 5 percent or more for several consecutive years, followed by increases of similar magnitude for several years, only to shift back again. These projections are based on constant rates of inflation (2 percent), enrollment changes, GDP growth and utilization growth. There is a serious problem when constant, stable rates of change in the factors driving the targets lead to extreme volatility in payments that are entirely formula-driven.

A primary reason for this instability is the fact that there is a time lag in measurement periods for the SGR. Specifically, while physician payment updates are established on a calendar year basis, SGR targets are established on a federal fiscal year basis (October 1 through September 30) and cumulative spending (used to calculate the SGR) is established on an April 1 through March 31 basis. These time periods must all be consistent and calculated on a calendar year basis to attempt to restore some modicum of stability to the SGR system.

Simulations by the AMA and MedPAC have also shown, however, that the change to a calendar year system will not, by itself, solve the instability problem. Additional steps would be needed. The wide range of updates that are possible under the current system, from inflation +3 percent to −7 percent, is one reason for the instability. The lower limit is also unacceptably low, and, assuming an MEI of 2 percent, represents an actual 5 percent cut in the conversion factor in a single year. These levels of payment cuts would be highly disruptive to the market, and likely would have the "domino effect" of impacting the entire industry, not simply Medicare fee-for-service. Many managed care plans, including Medicare+Choice and state Medicaid plans, tie their physician payment updates to Medicare's rates. Thus, payment limits under current law must be modified to assist in stabilizing the SGR system. We recommend that the current limits on physician payment updates (MEI +3 percent to MEI −7 percent) be replaced with new, narrower limits set at MEI +2 percent and MEI −2 percent.

Finally, use of the GDP itself also contributes to the instability of the payment updates since GDP growth fluctuates from year to year. Thus, we recommend measuring GDP growth on the basis of a rolling 5-year average.

Payment Preview Reports. Finally, MedPAC has also recommended that Congress should require the Secretary of the Department of Health and Human Services to publish an estimate of conversion factor updates prior to the year of implementation. We agree.

When the SGR system was enacted to replace the previous Medicare Volume Performance Standards, the requirements for annual payment review reports from HCFA and the PPRC were eliminated along with the old system. Without these re-

ports, it is impossible to predict what the payment update is likely to be in the coming year, and it is impossible for Congress to anticipate and respond to any potential problems that may ensue from an inappropriate update or a severe projection error.

Changes in Medicare physician payment levels have consequences for access to and utilization of services, as well as physician practice management. These consequences are of sufficient importance that the system for determining Medicare fee-for-service payment levels should not be left unattended on a kind of "cruise control" status, with no "brake" mechanism available to avoid a collision.

The AMA, therefore, urges that the payment preview reports be reinstated. Specifically, we believe that HCFA should be required to provide to MedPAC, Congress and organizations representing physicians quarterly physician expenditure data and an estimate each spring of the next year's payment update. MedPAC could then review and analyze the expenditure data and update preview, and make recommendations to Congress, as appropriate.

Conclusion

Enactment of the SGR system improvements recommended by MedPAC are critical to the continued ability of our nation's physicians to continue to offer our Medicare patients the finest medical care in the world. If these improvements are not put in place, the SGR system could lead to severe payment cuts in the Medicare physician fee schedule and payments for services that do not accurately reflect their costs. The cuts resulting from both the statutory design of the SGR system and administration of the system by HCFA would be in addition to more than a decade of cuts in physician payments. For example, in the six years from 1991–1997, overall Medicare physician payment levels fell 10 percent behind the rate of growth in medical practice costs. Many individual services and procedures faced even deeper cuts.

Recent survey data from the AMA's Socioeconomic Monitoring System indicates that these payment changes are having very significant effects on the practice of medicine. Of 2,450 randomly selected physicians that were surveyed from April-August 1998, 35 percent reported they are not renewing or updating equipment used in their office, are postponing or canceling purchasing equipment for promising new procedures and techniques, or are performing many procedures in hospitals that were formerly performed in the office. Three quarters of these physicians reported that Medicare payment cuts were an important factor in their decisions to defer or cancel these investments in capital.

With these kinds of changes already taking place in response to previous payment changes, we have grave concerns about the effects of the further reductions that could take place due to the SGR or incorrect practice expense values. In order for the medical innovations that will come from Congress' enhanced funding of biomedical research, FDA modernization, and better Medicare coverage policies to translate into ever-improving standards of medical care, physicians must be able to adopt these innovations into their practices. It is already clear that Medicare payment cuts are threatening continued technological advancement in medicine, and this is a threat that affects all of us, not just Medicare beneficiaries. Clearly, reversal of the trend to move services away from inpatient sites into ambulatory settings could also have severe consequences for health care costs, as well as patient care.

We appreciate the efforts of the members of the Subcommittee to explore the problems presented by the SGR system, as well as the opportunity to discuss our views on this extraordinarily important matter. We urge this Subcommittee and Congress to consider MedPAC's recommendations and the recommendations we have discussed today, and are prepared to engage fully in detailed discussions with the Subcommittee and Congress as we work to achieve a workable and reasonable solution.

Mr. McCrery. Next we have Maribeth Capeloto, director, Federal Relations, Group Health Cooperative, from Seattle, Washington. Ms. Capeloto, did I pronounce your name correctly?

Ms. Capeloto. Yes, you did.

STATEMENT OF MARIBETH CAPELOTO, DIRECTOR, FEDERAL RELATIONS, GROUP HEALTH COOPERATIVE OF PUGET SOUND, SEATTLE, WASHINGTON, ON BEHALF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS

Ms. CAPELOTO. Thank you Mr. McCrery. Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to comment on issues related to implementation of the Medicare+Choice program. I am Maribeth Capeloto, director of Federal Relations, and a former administrator of government programs for Group Health Cooperative based in Seattle, Washington. I am testifying today on behalf of the members of the American Association of Health Plans which represents more than 1,000 HMOs, PPOs and similar network health plans.

Let me begin by saying, Mr. Chairman, that we still support the goals of the BBA to expand choices for seniors, to enhance benefits, integrate care and benchmark quality. We are suffering through some unintended consequences rights now of what was major structural change.

It was with your leadership on the Bipartisan Commission on the Future of Medicare that a premium support model for Medicare was developed. If a premium support model for Medicare is to be successful in the future, it is imperative that the Medicare+Choice program be stabilized now. Beneficiaries deserve and are demanding a smoother transition of the Medicare+Choice program as envisioned by the Congress.

Group Health is a not-for-profit company and is the Nation's largest consumer-governed health care organization. We signed our first Medicare HMO contract more than 20 years ago in 1976 and at present serve nearly 60,000 Medicare beneficiaries. I am sad to report that effective January 1st, 2000 Group Health will withdraw from counties which will affect over 4,000 enrollees. In some of these counties there are no other health plan options for beneficiaries.

It is indisputable that HCFA faces an enormous task in implementing the Medicare+Choice provisions of the BBA. The policy goals may be supportable but the time line that HCFA has set and the choices they have made have contributed to the program's instability. This has contributed to the unfortunate decisions made by plans including Group Health to curtail their participation in the Medicare+Choice program.

As a consumer-governed HMO, decisions to leave markets are extremely painful for us, especially since, as I stated before, we have served beneficiaries for over 20 years as a risk contractor and have been in Washington State serving seniors since 1947.

The approach HCFA took in designing the risk adjuster is perhaps the most visible example of a policy decision that has challenged the Medicare+Choice program. Rather than implementing the risk adjuster in a budget-neutral manner, which it has the administrative authority to do, HCFA's design will reduce payment by another 11.2 billion over the next 5 years.

While we support risk adjustment as a necessary goal, the reductions due to the risk adjuster as currently constructed diminish the effectiveness of the floor and blended payment methodology, central reforms approved by the Congress. Year 2000 is the first year that

any counties received blended payments. New data this week suggests that the blend will not be funded in 2001. Even in some blended counties like those we serve, the risk adjuster reduced payments, even when our rates are below the national average. For example, when fully implemented in 2004 in Seattle, the risk adjuster will decrease payments by 6 percent; and in Spokane, a more rural area, the risk adjuster would decrease payments by 8.8 percent.

The impact of the risk adjuster in combination with the lack of predictability in the blend being implemented from year to year, creates massive instability in the program. The user fee for beneficiary education further erodes our already low payment rates.

Group Health has partnered with HCFA for more than 20 years. We disagree with HCFA's characterization that plans are unstable partners. The regulatory framework that HCFA has adopted since the BBA is far more onerous than anything we have experienced in the past 2 decades. The examples of burdensome and costly regulations are numerous: data collection, new reporting requirements, Y2K compliance. Also frustrating is the lack of clarity or completion of other regulations these delays, which are also expensive. The GME carveout regulations are an example here.

Beneficiary education is something we take very seriously as a consumer-governed cooperative. Last week HCFA required us to send a HCFA-drafted 13-page letter to beneficiaries in counties we are exiting. The HCFA-drafted letters that we had to mail on our letterhead were confusing and contained, in our view, unnecessary language. Their letter to ESRD enrollees, some of our more vulnerable members, required us to inform these patients about ESRD demonstration projects that are 1,500 miles away and that none of them could access.

I can not emphasize enough how important it is to stabilize the Medicare+Choice program. Our beneficiaries, your constituents, deserve better. We stand ready to work with you, Mr. Chairman and members of the subcommittee, to address the current challenges facing the program and to honor the intention of the Congress when it approved the BBA.

Chairman THOMAS [presiding]. Thank you very much.

[The prepared statement follows:]

Statement of Maribeth Capeloto, Director, Federal Relations, Group Health Corporative of Puget Sound, Seattle, Washington, on behalf of American Association of Health Plan

I. INTRODUCTION

Mr. Chairman and members of the Subcommittee, thank you very much for the opportunity to comment on issues related to the Health Care Financing Administration's (HCFA) implementation of the Medicare+Choice program. I am Maribeth Capeloto, Director of Federal Relations and former Administrator of Government Programs for Group Health Cooperative, based in Seattle, Washington. Group Health is a not-for-profit company and is the nation's largest consumer-governed health care organization. We signed our first Medicare HMO contract more than 20 years ago in 1976 and at present serve nearly 60,000 Medicare beneficiaries.

I am testifying today on behalf of the members of the American Association of Health Plans (AAHP), which represents more than 1,000 HMOs, PPOs, and similar network health plans. AAHP's membership includes the majority of Medicare+Choice organizations, which collectively serve more than 75 percent of beneficiaries in the Medicare+Choice program. Together, AAHP member plans provide care for more than 150 million Americans nationwide and have strongly supported efforts

to modernize Medicare and give beneficiaries the same health care choices that are available to working Americans.

AAHP's member plans have had a longstanding commitment to Medicare and to the mission of providing high-quality, comprehensive, cost-effective services to beneficiaries. In fact, like Group Health, many of our fellow member plans have served beneficiaries since the inception of the Medicare HMO program fifteen years ago, if not before, when the program was offered as a demonstration. In establishing the Medicare HMO program, Congress and the Administration were seeking to offer beneficiaries more coverage choices—choices through which plans could offer beneficiaries additional benefits not available in fee-for-service Medicare in exchange for a more limited provider panel. The new program was viewed as a milestone, holding both opportunities and challenges for the government, health plans, and beneficiaries. Over time, the number of Medicare HMOs steadily increased, reaching 346 in 1998. More than 17 percent—or 6.2 million beneficiaries—have voluntarily chosen a health plan over fee-for-service Medicare, up from only six percent just five years ago.

According to recent research, health plans are attracting an increasing number of older Medicare beneficiaries and beneficiaries are remaining in health plans longer. In addition, near-poor Medicare beneficiaries are more likely to enroll in health plans than higher-income beneficiaries. An AAHP analysis of Medicare Current Beneficiary Survey (MCBS) data shows that minority beneficiaries are at least as likely to be in Medicare+Choice as in fee-for-service Medicare. These health plans offer Medicare beneficiaries numerous benefits that are not covered under fee-for-service Medicare, such as full year's hospitalization, lower copayments and deductibles, and prescription drug coverage (Figure 1).

Figure 1: Comparison of Medicare+Choice and Fee-For-Service Benefits

	Medicare+Choice	Fee-For-Service
Outpatient Prescription Drug Coverage.	Yes	No
Deductible for Physician Visits	No	Yes, $100
Copayment for Physician Visit ..	Nominal copayment	20 percent coinsurance after $100 deductible
Hospital Inpatient Cost-Sharing	Typically, No	Yes
Day Limit on Extended Hospital Coverage.	Typically, No	Yes

Recent studies also highlight Medicare beneficiaries' high levels of satisfaction with their Medicare health plans. HCFA data show that, among beneficiaries with strong preferences, HMOs have a larger proportion of very satisfied enrollees than fee-for-service Medicare. A July 1997 study by CareData in conjunction with Towers Perrin also revealed very high rates of enrollee satisfaction among retirees who joined Medicare HMOs offered by their employers. Overall, almost 70 percent of retirees enrolled in an HMO that offered Medicare coverage were extremely or very satisfied with their HMOs.

The strong and steady growth in the number of beneficiaries who chose a health plan over fee-for-service Medicare and plans that participate, along with the high-levels of satisfaction, signaled a program that was flourishing. In approving the Balanced Budget Act (BBA) two years ago, Congress sought to build on the success of the Medicare risk program and to expand coverage choices even further, while at the same time taking steps toward ensuring the solvency of the Medicare trust fund. The establishment of the Medicare+Choice program was supported by AAHP and regarded as the foundation for moving forward with a program design that can be sustained for future generations of Medicare beneficiaries. Without action this year, the promises made to beneficiaries with the passage of the BBA will remain unfulfilled, and of equal importance, prevent the successful implementation of virtually every long-term Medicare reform initiative that this Subcommittee might examine.

II. Current State of the Medicare+Choice Program

The Medicare HMO and Medicare+Choice programs share the fundamental goal of expanding availability of new Medicare coverage options. But rather than continuing to evolve and grow, the Medicare+Choice program is devolving and contracting. As members of the Subcommittee know, the first public sign of trouble in the Medicare+Choice program surfaced last fall when nearly one hundred health plans were forced to reduce or end their participation in the program, resulting in

more than 400,000 beneficiaries losing their health plan choice. Fifty thousand of these beneficiaries were left with no other health plan option. At that time, AAHP and others urged the Administration and Congress to make mid-course corrections, arguing that if program problems were left unaddressed, more health plans, many of which have participated in the program for years, would face the same difficult decisions in 1999 and beyond. As members of the Subcommittee fully know, this concern became the unfortunate reality.

In mid-July, HCFA announced that 327,000 beneficiaries in another ninety-nine health plans, including some enrollees in Group Health, would lose their health plan on January 1, 2000. Of the 327,000 affected beneficiaries, 70,000 will have no choice but to return to the fee-for-service program because there is no other Medicare+Choice plan in their area. Although total enrollment in Medicare+Choice has increased, the year to date growth rate has fallen dramatically to 6.8 percent for the first eight months of 1999. Growth between January and September in 1998 and 1997 was 11.1 percent and 17.4 percent, respectively. Between August and September 1999, fewer than 25,000 beneficiaries joined Medicare+Choice plans, compared to the pre-BBA monthly average of approximately 100,000 beneficiaries.

In addition to these sobering events, three months ago, on July 1st, AAHP released results of a survey of its 26 largest members that participate in the Medicare+Choice program, which showed that among responding organizations, a substantial number of beneficiaries who will be able keep their plan next year will face increased out-of-pocket costs and reductions in benefit levels. AAHP's survey results, which were independently collected and tabulated by Peter D. Hart Research, showed that premium changes to be instituted by 18 companies will affect nearly 1.5 million of the 3.86 million beneficiaries covered by the survey whose plans will remain in the program next year. Among these individuals, monthly premiums will increase by $20 or more for 926,009 persons and $40 or more for 400,757 of the 926,009 persons. Monthly premiums will decrease for just fewer than 12,000 individuals; in all instances, these decreases will be less than $20. More than 1.3 million enrollees will face an increase in prescription drug copayments, while just 10,000 enrollees will have decreased prescription drug copayments next year. Additionally, about 600,000 individuals covered by the survey will face hospital inpatient copayments averaging $275 next year.[1] These results coincide with those of an Administration survey released less than two weeks ago.

III. Sources of Medicare+Choice Program Instability

The health plans that announced their decisions to leave the Medicare+Choice program or to reduce benefits did not make their decisions lightly. Many of these plans worked up to the July 1st deadline to devise strategies that would enable them to maintain their current service area, to stay in the program next year, or to minimize benefit reductions. But for many of these plans, current problems with the Medicare+Choice payments and increased regulatory burdens were too overwhelming, and they were forced to reduce their participation, to withdraw from the program or to scale-back benefits. Without a doubt, HCFA's approach to implementing policies and changes required by the BBA have influenced these decisions.

Medicare+Choice Payment

HCFA Risk-Adjustment Approach Undermines BBA Medicare+Choice Payment Reforms Goals. The BBA limited the annual rate of growth in payments to health plans, producing $22.5 billion in savings from the Medicare+Choice program. The BBA also sought to reduce geographic variation in payments to encourage the development of coverage choices in areas of the country with lower payments. In 1998 and 1999, however, no counties received blended payment rates because of the low national growth percentage and the inability to achieve budget neutrality.

AAHP and its member plans supported the passage of payment reforms in the BBA and understood the need to contribute our fair share toward the savings necessary to stabilize the Medicare Trust Fund. We are deeply concerned, however, that administrative actions taken by HCFA affecting Medicare+Choice payments do not serve the best interests of beneficiaries and were not anticipated by Congress. Together with unintended consequences of higher than anticipated inflation,

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[1] In responding to the survey, plans were asked to provide information on the benefit arrangement that presently applies to the largest share of their Medicare+Choice enrollees. Plans were asked to describe the 1999 benefit, any change in the benefit to become effective on January 1, 2000, and the number of enrollees covered under the benefit. Using this information, Peter D. Hart Research estimated the number of enrollees affected by benefit changes and the magnitude of these changes among the subset of enrollees covered by the most common benefit arrangement. Not all companies responded to each question.

HCFA's actions are contributing to a growing gap in funding between the Medicare+Choice and fee-for-service sides of the program, which is undermining the program's stability.

As members of the Subcommittee know, Congress directed HCFA to establish a health-status based risk-adjustment methodology. HCFA has chosen to fulfill this requirement by implementing its new risk-adjustment methodology in a manner that will cut aggregate payments to Medicare+Choice organizations by an estimated additional $11.2 billion over a five-year period beginning in 2000. This is an administratively imposed increase in the $22.5 billion savings Congress expected from the payment methodology as enacted in the BBA. This reduction reflects only the first stage of risk-adjustment. According to the Administration, the second stage, which will be based on utilization in all settings, is expected to reduce payments by another 7.5 percent beginning in 2004 resulting in a 15 percent total reduction.

At the time of the BBA's approval, the Congressional Budget Office (CBO) did not score the new risk-adjuster as saving money. More recently, CBO stated that it had "previously assumed" that the health status-based risk-adjustment in the Medicare+Choice program would be budget neutral.[2] There is no doubt that HCFA has the authority to implement the risk-adjuster on a budget-neutral basis. Sadly, we already have begun to see the effects of HCFA's decision not to take this approach, which has contributed to the recent decisions by health plans to curtail their participation or to reduce benefits next year.

Short of any action—either administrative or legislative—the situation is not likely to improve. AAHP analyses of PricewaterhouseCoopers projections of Medicare+Choice rates in each county over the next five years shows that a significant gap opens up between reimbursement under the fee-for-service program and reimbursement under the Medicare+Choice program.[3] These analyses show that:

- The Medicare+Choice Fairness Gap will be at least $1,000 for two-thirds of Medicare+Choice enrollees living in the top 100 counties, as ranked by Medicare+Choice enrollment (Figure 2).
- For nearly half of Medicare+Choice enrollees living in the top 100 counties, government payments to health plans on behalf of beneficiaries will be 85 percent or less of fee-for-service Medicare payments in 2004, significantly exceeding estimates of so-called overpayment due to favorable selection by plans (Figure 3).
- In the top 101 to 200 counties as ranked by enrollment, nearly half of Medicare+Choice enrollees live in areas where the Fairness Gap will be $1,000 or more in 2004. These counties include smaller markets in which plans were expected to expand into under the policy changes implemented by the BBA.

Perhaps most importantly, AAHP found that a large percentage of the "Fairness Gap" is attributable to HCFA's risk-adjuster, the design of which is severely flawed. Rather than measuring health-status, as required by the BBA statute, HCFA's risk-adjustment method measures inpatient hospital utilization. This design penalizes numerous health plans, which like Group Health, use disease management programs that are designed to reduce hospitalizations for chronically ill patients who would have otherwise been treated in inpatient settings. These programs are structured to prevent costly hospitalizations by treating patients in alternative settings. Contrary to ensuring predictability in the new Medicare+Choice program, the impact of this risk-adjustment methodology will be to restrict new market entrants and leave beneficiaries with fewer options, reduced benefits and higher out-of-pocket costs. This result squarely contradicts Congress' goals in developing the Medicare+Choice payment reforms included in the BBA. AAHP has found, for example, that the impact of HCFA's risk-adjuster on Medicare+Choice payments to rural and urban counties is similar—rural areas with Medicare+Choice beneficiaries are cut by about 6 percent, while urban areas are cut by about 7 percent.

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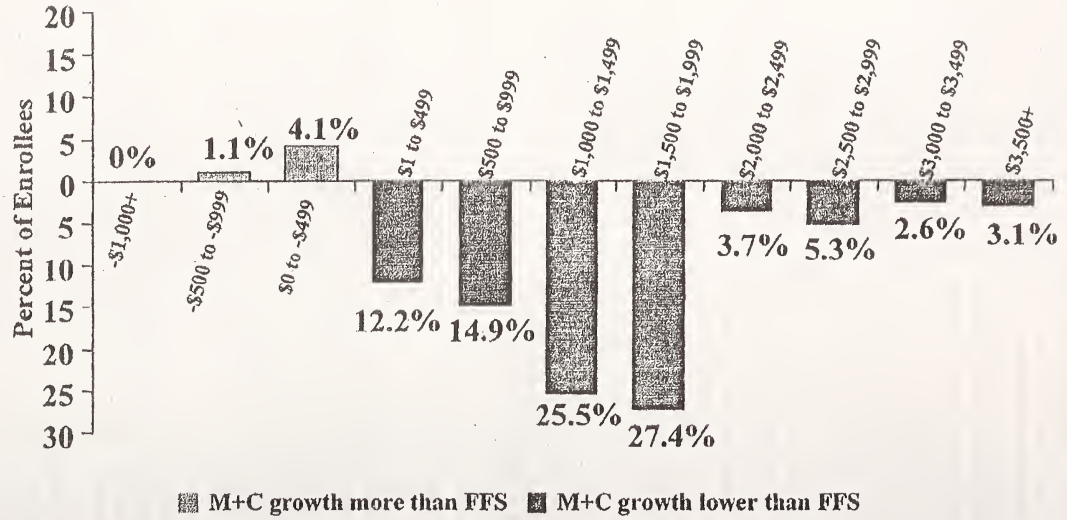
[2] "An Analysis of the President's Budgetary Proposals for FY 2000," Congressional Budget Office.

[3] AAHP calculation from PricewaterhouseCoopers (PWC) analysis prepared for AAHP, March 1999. AAHP's analysis produces conservative estimates of the Fairness Gap by assuming that county-level Medicare+Choice and FFS payments were equal in 1997, even though Medicare+Choice payments were actually lower than FFS per capita payments in 1997. PWC analysis based on first stage of risk adjustment. PWC analysis *does not* reflect second stage of risk adjustment, which HCFA expects to reduce payments by an additional 7.5 percent in 2004. The Fairness Gap represents growth between 1997 and 2004 in the projected difference between county-level aged Medicare+Choice risk-adjusted per capita payments and FFS per capita payments. Top 100 counties by enrollment account for 72 percent of enrollment.

Figure 2: The Fairness Gap--Top 100 Counties By Enrollment
Two-Thirds of M+C Enrollees Live In Areas Where
The Fairness Gap Will Be $1,000 Or More In 2004



Source: AAHP calculation from PricewaterhouseCoopers (PWC) analysis prepared for AAHP, March 1999. PWC analysis based on first stage of risk adjustment. PWC analysis does not reflect second stage of risk adjustment, which HCFA expects to reduce payments by an additional 7.5 percent in 2004. The Fairness Gap represents growth between 1997 and 2004 in the projected difference between county-level aged Medicare+Choice risk-adjusted per capita payments and FFS per capita payments. Top 100 counties by enrollment account for 72 percent of enrollment.

Figure 3: The Fairness Gap --Top 100 Counties By Enrollment
Nearly Half of M+C Enrollees Live In Areas Where The Fairness Gap Will Be 15 Percent Or More In 2004

Source: AAHP calculation from PricewaterhouseCoopers (PWC) analysis prepared for AAHP, March 1999. PWC analysis based on first stage of risk adjustment. PWC analysis does not reflect second stage of risk adjustment, which HCFA expects to reduce payments by an additional 7.5 percent in 2004. The Fairness Gap represents growth between 1997 and 2004 in the projected difference between county-level aged Medicare+Choice risk-adjusted per capita payments and FFS per capita payments. Top 100 counties by enrollment account for 72 percent of enrollment.

Another AAHP analysis of PricewaterhouseCoopers projections that incorporates the effect of the risk-adjustment methodology when it is phased-in at 10 percent indicates that nearly half of current Medicare+Choice enrollees live in areas in which year 2000 payments will increase by 2 percent or less over 1999 payments. This situation will likely worsen in 2001 when HCFA will base 30 percent of Medicare+Choice payments on its risk-adjustment methodology. This means that payments in many parts of the country will fall below the two percent minimum

update established by Congress. HCFA's risk-adjuster also will diminish the effectiveness of the blended payment methodology and payment floor in reducing geographic variation in Medicare+Choice payments.

Exclusion of Spending on Medicare-Eligible Retirees From Medicare+Choice Rate Calculation.

Spending on medical services furnished to Medicare-eligible military retirees by Department of Veterans Affairs (VA) and Department of Defense (DoD) hospitals continues to be omitted from the calculation of Medicare+Choice rates. A few years ago, the Prospective Payment Advisory Commission (ProPAC) estimated that health care provided in DoD and VA facilities to Medicare beneficiaries accounts for 3.1 percent of the total resource costs of treating Medicare beneficiaries. ProPAC concludes from its findings that the omission of the cost of care provided in DoD and VA facilities to Medicare beneficiaries leads to systematic errors in both the level and distribution of Medicare managed care payments. H.R. 2447, introduced by Congressman McDermott, represents one approach that would help address this problem by including these amounts in Medicare+Choice rate calculations.

Plans Have Limited Ability to Reflect GME Carve-Out In Contracts with Teaching Facilities.

In addition, the BBA sought to begin tackling some of the issues related to Graduate Medical Education (GME) reform by limiting the number of residents supported by the Medicare program and by providing incentives to hospitals to reduce the size of their training programs. However, a central BBA provision, the removal of GME funds from the calculation of payments to Medicare+Choice organizations, does not appear to address broader GME reform goals. Studies show that health plan members do use teaching facilities and that plan payments on behalf of a member receiving treatment in a teaching hospital greatly exceed payments for the same case in a non-teaching hospital. Although GME payments are being removed from Medicare+Choice payments, in many markets, the dominance of teaching hospitals limits health plans' ability to reflect the carve-out by making commensurate reductions in payments to teaching hospitals. Consequently, teaching hospitals are receiving GME payments from the Medicare program as well as higher payments from health plans. Ultimately, it is the Medicare beneficiary who bears the burden of these higher payments due to reductions in additional benefits that they otherwise would receive.

User Fee Further Erodes Medicare+Choice Payment Updates.

AAHP also has significant concerns about the funding of the Medicare beneficiary information campaign. While it is reasonable for health plans and their enrollees to contribute to funding HCFA's education and information dissemination initiatives, their contribution should be in proportion to their participation in the Medicare program. On average, generating the $95 million will require a tax of $1.90 each month for each beneficiary enrolled in a Medicare+Choice plan (the tax is collected over only the first nine months of the year). This $1.90 per month per beneficiary tax represents 18 percent of the average monthly 1998 to 1999 payment increase under the new BBA payment methodology.

AAHP supports the goal of providing beneficiaries with accurate information that allows them to compare all options and select the one that best meets their needs. Thus far, however, the campaigns have not met expectations. Many beneficiaries received incorrect or confusing information and some plans were left out of the brochure altogether. AAHP urges Congress to ask HCFA for an accounting of its use of resources for educational purposes. We also urge Congress to adopt MedPAC's recommendation to fund this program through HCFA's operating funds rather than a tax on Medicare+Choice enrollees. AAHP continues to believe that the entire beneficiary information program should be reevaluated and streamlined.

Stabilizing Payment Will Help Stabilize the Medicare+Choice Program

The present state of the Medicare+Choice program is not what Congress expected when the BBA was approved two years ago. Rather than having expanded coverage choices, beneficiaries face fewer coverage choices. Additional benefits offered by plans that are not available in the fee-for-service program are being jeopardized. Some have argued that HCFA overpays health plans and that plans withdrawing from the market are simply making "business decisions." In response, first let me say this: overpaid health plans do not leave a market. Overpaid health plans do not reduce benefits. Second, payment and regulatory requirements dictate the type of environment in which health plans participate in the Medicare+Choice "business." So yes, the current payment and regulatory environment is forcing plans to make

difficult business decisions regarding their participation in the Medicare+Choice program.

In the absence of an administrative action, H.R. 2419, introduced by Congressmen Bilirakis (R–FL) and Deutsch (D–FL), is one approach that would go a long way toward stabilizing the payment situation in both urban and rural areas by requiring that HCFA implement the new risk-adjuster on a budget-neutral basis, which is in keeping with Congressional intent. The bill also would ensure that national updates to government payments for beneficiaries choosing a Medicare+Choice plan grow at the same rate as government payments for beneficiaries choosing fee-for-service Medicare. H.R. 2419 represents one equitable approach to restoring funding by increasing the total dollars available in setting Medicare+Choice payment rates. This approach will help ensure that the BBA goal of expanding coverage choices for all beneficiaries is met.

Another way that payments could be stabilized is through establishment of a true payment floor. As discussed earlier in this testimony, Medicare+Choice payments are falling drastically relative to fee-for-service Medicare payments—in many areas, payments are falling to 80 percent or less of fee-for-service payment. To prevent this, a true floor could be set such that Medicare+Choice payments would not fall below a specified percentage of fee-for-service per capita payments in a county.

Medicare+Choice Regulatory Environment Contributes to Program Volatility

The challenges facing the Medicare+Choice program do not result from payment alone. HCFA's approach to overseeing the program and the structure of the Medicare+Choice program are contributing to the volatility in the program. Further complicating issues is the reorganization of HCFA, which has undermined communication between health plans and HCFA staff. Taken together, the issues of payment and regulation have challenged plans' abilities to maintain their health care networks. In an increasing number of cases, providers around the country simply have told health plans that given low payments and increased regulatory requirements on them, that they are better off just seeing beneficiaries under the fee-for-service program. Without an adequate provider network, health plans cannot meet HCFA's Medicare+Choice participation requirements leaving them with no other option but to exit the program.

HCFA Roles as Purchaser and Regulator in Conflict.

HCFA's dual roles as purchaser and regulator are, at times, in conflict, and nowhere has this conflict been more evident than in HCFA's implementation of the BBA. These role conflicts remain unresolved, even largely unaddressed. Until ways are found to reconcile them, however, they will stand in the way of designing and delivering a Medicare+Choice program that really works for beneficiaries. Unfortunately, there are numerous examples that point to this inherent conflict between HCFA's roles.

Request for Adjustments to ACRs. The circumstances that plans faced in the fall of 1998 perhaps best illustrate this situation. HCFA published the Medicare+Choice regulation, which was more burdensome than expected, nearly a month and a half after the date plans were required to file their 1999 adjusted community rate proposals (ACRs) last year. This situation and the unrealistic compliance deadlines, combined with the reduced rate of increase in payments and the uncertainty created by the new risk-adjustment model, were major factors in decisions by plans across the country and across model types to become deeply concerned last fall about the viability of the benefits and rates included in their ACRs on the originally mandated May 1st deadline. This led AAHP members to make an unprecedented request to HCFA to allow plans to resubmit parts of their ACRs. In some service areas, the ability to vary copayments—even minimally—meant the difference between a plan's ability to stay in the Medicare+Choice program or to pull out of a market.

While this request presented HCFA with a complicated situation, AAHP strongly believes that an affirmative decision would have been better for beneficiaries. As a purchaser, HCFA had a strong motivation to maintain as many options as possible for beneficiaries by responding to health plans' concerns and adopting a more flexible approach to Medicare+Choice implementation. As a regulator, however, HCFA had concerns about criticism that could result from reopening benefit and rate proposals, and thus chose not to allow any opportunity for adjustment of ACRs. HCFA's decision in part contributed to the withdrawal of nearly 100 health plans from the program, affecting more than 400,000 beneficiaries. This unfortunately is not the only example of a policy decision made by HCFA that is undermining the fulfillment of the BBA goals.

HCFA to Implement QISMC without Exercising Deeming Authority. The provisions of the BBA concerning quality oversight standards for Medicare and Medicaid

participating health plans call for an implementation that builds upon the quality improvement standards of existing accreditation organizations and avoids duplicate reviews. AAHP has long advocated for coordination of quality standards for health plans in order to maximize the value of plan resources dedicated to quality improvement. In an effort to avoid duplication with other quality initiatives undertaken by plans, the BBA explicitly authorizes HCFA to develop a process through which health plans would be "deemed" to meet quality-related requirements. Unfortunately, HCFA has chosen to begin implementation of its Quality Improvement System for Managed Care (QISMC) and it has done so without completing work that will permit Medicare+Choice plans to take advantage of the statutory authority for deeming.

HCFA's Approval Process for Marketing Materials Creates Delays. HCFA recently issued a standard summary of benefits document to facilitate the comparison of benefits offered by health plans. AAHP supports the goal of this project, however, we believe it was completed on a timeframe that did not allow for the completion of necessary development work. As a result, HCFA made modifications to improve the document even after plans had been asked to submit compliant materials. The Agency now is in the process of revising its model evidence of coverage (EOC). Some HCFA regional offices are delaying approval of plans' EOCs pending their receipt of the new model EOC from the central office. These examples clearly indicate the need to devote adequate time to projects and the need for clear communication between central and regional HCFA offices on the effective date of new requirements, such as the use of the revised EOC.

IV. Solving the Problems that Undermine the Success of the Medicare+Choice Program

The Medicare+Choice program is critical to strengthening and stabilizing Medicare over the long term. There is no doubt that HCFA faces an enormous task in implementing the BBA. But as we have described in this testimony, we believe that HCFA has made decisions and taken approaches that clearly do not serve the best interests of beneficiaries. AAHP and its member plans stand ready to provide assistance as policymakers work to understand the combination of factors that threaten the success of the Medicare+Choice program. We emphasize that it is in everyone's interest—including beneficiaries, providers, health plans, HCFA and Congress—for the BBA to achieve its full promise. Our concern last year that without action, more beneficiaries would lose access to their plan and that others would face reductions in benefits has become a dismal reality. Further delay in instituting administrative and legislative remedies could render the Medicare+Choice program beyond repair or salvage. This outcome would be a loss not only for the beneficiaries who have chosen a Medicare+Choice plan, but also for future beneficiaries who would be denied the opportunity to do so.

Chairman Thomas. Mr. Hendrickson.

STATEMENT OF BLAINE HENDRICKSON, INDEPENDENT OWNER, LEGACY HEALTH CARE, RANCHO MIRAGE, CALIFORNIA, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION

Mr. Hendrickson. Thank you, Mr. Chairman and Members of the Subcommittee. Thank you for allowing me the opportunity to appear before you today. I would like to take this opportunity to share the concerns of skilled nursing providers as we navigate our way through the recently implemented SNF protective payment system.

My name is Blaine Hendrickson and I operate three independent nursing facilities in the Indio and San Bernadino areas of California. I speak today on behalf of the American Health Care Association. Because of the way the SNF PPS has been implemented, many Medicare beneficiaries are not gaining access to the skilled nursing care they need. Skilled nursing providers, particularly

those who specialize in caring for the sickest Medicare patients, are facing a serious financial crisis. This is forcing many of us throughout the Nation to reexamine our ability to participate in the Medicare program.

I am one of those facilities. I operate a facility in Indio, California, a small rural community. In 1997, because of our reputation of quality care-giving, we were asked to take over a small 68-bed facility. I agreed, and in my efforts I found that the facility was not meeting the needs of the community. As a result, we went from providing no Medicare to an average of 12 to 14 Medicare residents to respond to the community's need.

However, with the new Medicare cuts, we have gone from an average reimbursement of $408 a day to an average of $231, which is impossible to do. I am talking about patients who need 24-hour medical attention, extensive therapy, IV antibiotics and a host of medications, all for $231 a day, far less than our resources can provide.

So in my community, Medicare patients now face the possibility of having to go hours away from family and friends. The problem is that simple and must be fixed now.

Let me tell you what this means for Medicare's sickest beneficiaries. If Medicare funding levels are not restored, already reduced access to patient care will continue to erode. Already, availability of capital for facility improvement and nurse staffing has vanished and a growing number of skilled nursing facilities throughout the Nation will be forced to close their doors. This is not limited to just the large national companies but to small providers such as me.

Small providers like me are finding it difficult to survive. We are struggling with a government asking us to do more with much less. It cannot be disputed that access problems exist for Medicare SNF patients. In fact, a recent OIG report showed that the majority of hospital discharge planners, 58 percent in fact, identified patients who require extensive services have become more difficult to place in SNFs since Medicare cuts have been implemented.

The Medicare cuts are affecting our employees as well. The bleak outlook for SNFs is creating an environment that will not allow us to attract and retain the high-quality professional staff. These deep cuts will have forced layoffs of tens of thousands of employees. That is a fact.

Mr. Chairman, I have been blessed with a 14-year-old son named Ricky who was born with spina bifida. Medical professionals told our family he wouldn't survive for more than 5 years. And they urged us to institutionalize Ricky because his condition required ongoing medical—complex medical attention. Only one facility in California was capable of caring for him and that facility was hundreds of miles away from our home and our community. I can't begin to describe the emotional turmoil our family experienced, feelings of overwhelming guilt, anxiety, hopelessness and questions about whether or not we would be abandoning our son. But our family was lucky. My wife was able to devote herself full time to being Ricky's caregiver. And so rather than send him hundreds of miles away to receive the care he needed, we cared for our son at home. But for many, caring for a loved one at home is not possible.

Mr. Chairman, as my time runs down, I would like to propose four recommendations to improve access and to improve the program under Medicare PPS:

No. 1, create payment add-ons for certain RUG categories effective October 1. HCA supports Senate bill 1500. Currently there is no House companion, but we hope the House will consider a similar proposal as you begin to markup. It is critical to identify where these patients with high-cost intense medical needs which are covered in the PAPS system make payment add-ons to address the disparity between the cost of providing these services and the resources Medicare currently provides.

No. 2, update the current SNF market basket effective October 1, 1999. The current market basket grossly understates the actual market conditions for SNFs. Mr. Chairman, for some time you made it clear that the administration should do its part in refining the system. We agree. HCFA has a legal authority to address the inequities of the SNF market basket. In fact, at the request of the White House, we provided them with the legal opinion making clear their legal authority and we will submit that for the record.

Mr. HENDRICKSON. No. 3, allow providers to transition to the Federal rate effective October 1, 1999. PPS rates are based on cost reports that date all the way back to 1995. This puts some providers at a disadvantage. Providers should have the option of electing to move to the full Federal rate immediately if they show they are disadvantaged by PPS.

And finally, Medicare beneficiaries would achieve great relief if Congress would pass Mr. McCrery's and Mr. Cardin's H.R. 1837. Mr. Chairman, I thank you for the opportunity to be here today. The majority of my residents have served this country in extraordinary ways and it is a privilege to serve them today. Thank you.

Chairman THOMAS. I would just tell you, Mr. Hendrickson, your statement was superb timing on the one particular bill that you mentioned. We won't put that to a vote right now. We will wait until later.

[The prepared statement follows:]

Statement of Blaine Hendrickson, Independent Owner, Legacy Health Care, Rancho Mirage, California, American Health Care Association

Thank you, Chairman Thomas and Members of the Ways and Means Health Subcommittee, for allowing me to appear before you today. I would like to use this opportunity to share the concerns of skilled nursing facility (SNF) providers as we navigate our way through the challenges of the recently implemented SNF prospective payment system (PPS) and other issues brought about by the Balanced Budget Act of 1997 (BBA).

My name is Blaine Hendrickson, and I operate three independent nursing facilities in the Indio and San Bernardino areas of California. I speak today on behalf of the American Health Care Association (AHCA), a federation of 50 affiliated associations representing over 12,000 non-profit and for-profit assisted living, nursing facility, and subacute care providers nationwide.

Mr. Chairman, balancing the budget and controlling Medicare spending in an effort to save the program and ensure its financial viability for future generations is a laudable goal. In fact, our commitment to that goal was evident when AHCA voiced strong support for the development and implementation of a new prospective payment system (PPS) under Medicare. We understood that such a system would encourage operational efficiencies and ultimately reduce Medicare spending for patients needing skilled nursing care.

However, because of the way the SNF PPS has been implemented, and to some extent because of language contained in the Balanced Budget Act itself, significant numbers of Medicare beneficiaries are not gaining access to the skilled nursing care

they need. These beneficiaries need your help. Skilled nursing providers themselves, particularly those who have specialized in caring for the sickest Medicare patients, are facing a serious financial crisis, which is forcing many of us throughout the nation to re-examine our ability to participate in the Medicare program.

The BBA intended to reduce Medicare payments in 1999 from $248 billion to $232 billion. In September, however, the Congressional Budget Office estimated that actual payments will be only $210 billion. That $22 billion shortfall was not expected and has created chaos for providers and seniors.

I must be honest with you: I'm not the least bit comfortable sitting in front of you here today discussing inadequate Medicare funding in the same sentence with providing care for our nation's most vulnerable citizens—the frail, sick, and elderly. But I am not going to hide behind rhetoric. People put their lives and the lives of their loved ones—*our* residents—in *our* hands—24 hours a day, truly a daunting responsibility that we take very seriously. It is a very difficult and challenging job, but we provide this skilled nursing care with dedication and compassion.

The sheer numbers of Medicare patients are growing every day, and the demands put on us for quality skilled nursing care also grows with this increased need for care. Our nation's elderly are living longer, fuller lives. And the advanced skilled nursing care for supporting this gift of extended life and extended living through advanced medicine and technology requires ever-increasing, highly advanced skilled nursing care, additional therapies and life-enhancing medicines. Skilled nursing facilities simply cannot provide these services for the most medically complex and frail patients without a system in place that supports our patients' additional medical needs. I am one of those facilities.

Mr. Chairman, I operate a facility in Indio, California—a small, rural community not unlike the community you come from. The state Department of Health approached me several years ago to take over a small, 68-bed facility because of my record in quality caregiving. In my efforts, I found that the facility was not meeting the needs of the community with regard to Medicare patients. Patients were having to leave our community to access facilities far away in order to get the care they needed. So we went from no Medicare beds to 12–14 beds out of the 68 beds we have.

However, with the new Medicare cuts, we went from an average of $408 a day for reimbursement for medically complex patients to an average of $231, which is simply impossible to do. We're talking about patients who need 24-hour medical attention, extensive therapy, IV antibiotics, G-tubes, a host of medications, and other services, all for $231 day, significantly less than our resources can provide. So in my community, Medicare patients are now having to leave their communities to get care, sometimes hours away from family and friends. The problem is as simple and as complex as that. The problem is very real. And the problem must be fixed now.

One important indicator of the urgency and severity of the problem is a capitalization of the health care sector. In the past 18 months, market capitalization for hospitals has dropped approximately 40%. The skilled nursing industry market capitalization has dropped by almost twice as much—nearly 75 percent. We—providers, policymakers, families, and Medicare beneficiaries themselves—are facing a crisis of incredibly significant proportions. Time is of the essence. The situation will worsen unless you take action.

Just a few weeks ago, one large national provider of skilled nursing services, filed for chapter 11 bankruptcy protection. This is part of a growing national trend. This, I fear—I know—is just the tip of the iceberg. We are witnessing this dramatic impact only four months into full implementation of the new prospective payment system. Providers are struggling. Patients are being affected. And families are concerned.

Let me tell you what this means for Medicare's sickest beneficiaries. If Medicare funding levels are not restored, already reduced access to patient care will continue to erode. Already, availability of capital for facility improvement and nursing staff will vanish, and growing numbers of skilled nursing facilities throughout this nation will be forced to close their doors. And this is not limited to just the large national companies that provide care to tens of thousands of elderly and disabled, but to regional providers, small providers such as me, both non-profit and for-profit facilities.

I have had the opportunity to travel throughout the country to talk with other skilled nursing providers across the country. I can tell you from that experience, this is not a problem that affects only national companies, as you may have been led to believe. This problem is rampant among skilled nursing providers who care for the sickest Medicare beneficiaries. We are committed to continuing to provide the highest quality of care. And—so far—we are doing everything possible to refrain from laying off direct caregivers, the men and women on the front lines of health care, ensuring a high quality of clinical care and a high quality of life for our pa-

tients. These providers also are cautious about discussing the impact these cuts are having because, quite honestly, we do not want to create a sense of fear in the hearts of residents and families who depend on us. Right now, some of us are getting by with dramatically reduced resources. How much longer can we do this? Only time will tell. Small providers like me, who fly below your radar, are finding it very difficult to survive. We are struggling with a government asking us to do much more with much less—demanding higher levels of quality in the face of drastic cuts. It simply doesn't make sense. It's hurting America's elderly. And America's seniors deserve better.

I have been a health care provider with an excellent record for 30 years, and in that time, I have never been as concerned as I am now about our ability to continue serving seniors and the disabled. I am concerned about real people facing very real problems—problems of access to needed care.

No one disputes that access problems exists for Medicare SNF patients. In fact, an OIG report, seeking to examine access problems to skilled nursing care, showed that the majority of hospital discharge planners (58%) identify patients who require extensive services have become more difficult to place in SNFs since Medicare cuts have been implemented. "These types of patients typically require complex direct nursing care and expensive medications, and they include patients who require intravenous feedings, intravenous medications, tracheotomy care or ventilator care," the report says.

Additionally, one-third of discharge planners said it was difficult to place Medicare patients in SNFs, and 65 percent said PPS has had an effect on their ability to place patients.

The access problem is occurring because SNFs are being forced to reevaluate the extent to which Medicare will allow them to appropriately care for the sickest patients.

The Medicare cuts that are denying beneficiaries access to care are not just affecting Medicare beneficiaries, but are affecting our employees as well. The bleak outlook for SNFs is creating an environment that will not allow us to attract and retain high quality professional staff. These deep cuts have forced layoffs of tens of thousands of employees. That is fact. Mr. Chairman, the job of skilled care staff is challenging under any circumstances, but I can say with certainty that these dramatic reductions add a new degree of difficulty in providing access to high-quality care that Medicare beneficiaries expect and deserve.

I have been blessed with a 14-year old son named Ricky, who was born with spina bifida and severe complications related to his condition. Medical professionals told our family that Ricky wouldn't survive for more than five years. And they urged us to institutionalize Ricky because his condition required ongoing complex medical attention. Only one facility in California was capable of caring for Ricky, and that facility was hundreds of miles away from our home and our community. I can't begin to describe the emotional turmoil our family experienced—feelings of overwhelming guilt, anxiety, hopelessness, and questions about whether or not we would be abandoning our son. I can tell you that without question, that was the most difficult time of my life. But our family was lucky. My wife was able to devote herself fulltime to being Ricky's caregiver. And so, rather than send him hundreds of miles away to receive the care he needed, we cared for our son at home. But for many families in America, caring for a loved one at home is simply not possible. And I know too well what it's like to be faced with the decision to move someone you love far from home—simply to receive health care.

These cuts have created another sad and difficult reality for patients and families: patients who are discharged from hospitals to skilled nursing facilities are being forced to use facilities far away from family and loved ones to receive the specialized care they need, because many facilities in their vicinity are no longer providing that level of skilled nursing care.

You may ask why this is a problem. First, let me ask you, how would you like to face a very difficult and emotional decision of having to put a loved one in a facility because you can no longer care for them yourself? Those of you here today who have gone through that process know what I am saying, you know how difficult that decision is. Now, add to that the decision to place a loved one in a facility that is a hundred miles away from home, because skilled nursing care in your community isn't available. And forcing patients into health care settings far from home makes daily or even weekly visits impossible. This not only affects the family deeply, it also interferes with the patient's recovery and emotional well being. I count my blessings every day that I have not had to make that decision for Ricky.

The other real problem that Medicare cuts are having on Medicare beneficiaries—one I know everyone sitting here has heard about—is the arbitrary cap imposed on nursing home residents for life-enhancing rehabilitation therapies. These caps on

Part B therapies, which are set at $1500 per year, have had a terrible effect on certain residents across the country. The combined $1500 limit on speech therapy and physical therapy and the additional $1500 cap on occupational therapy are threatening patient access to life-enhancing care. For example, this flawed policy is forcing patients—patients recovering from stroke and other serious conditions-to choose between therapy to enable them to either walk or talk because Medicare resources simply will not cover both. Imagine sitting with your family, trying to decide whether your mother or father should receive physical therapy after a stroke in order to walk again, or receive speech therapy in order to talk again, or even swallow appropriately. You might think I am being overly dramatic, but families *are* faced with this cruel and difficult decision—even as I sit before you right now. This tragedy is best illustrated by looking at a real life example of how a Medicare beneficiary's life has been changed.

This example involves an 85 year-old woman named Frances. Frances owned her own hat making shop here in Northwest Washington. Frances had a stroke early this year and suffered from right-side paralysis as a result. She could not walk, speak, or take care of herself in her activities of daily living such as bathing, eating, dressing, or toileting. She received physical therapy to teach her how to walk again, and was able to walk from her room to the TV room with a walker and a nurse aide behind her. Her speech therapy was helping her to relearn how to swallow and speak again. Unfortunately, she exceeded the $1500 cap on June 23rd, and now the facility provides care to her without reimbursement and tries to stretch its resources to prevent any decline. Frances also received occupational therapy which taught her how to take a bath by herself, get dressed by herself (with help in the room if needed), and toilet by herself. She had regained independence in her life. Unfortunately, Frances has also exceeded her occupational therapy cap and is now in danger of losing some of the skills and quality of life she had gained.

The facility is doing the best it can to care for their residents, but 10% have exceeded the speech/physical cap and about 5% have met or will exceed the occupational therapy cap. Care for our nation's frail elderly is being rationed, and in many cases they are not getting the amount of therapy they need. If after meeting the cap, a resident falls, is hospitalized and needs skilled therapy in the same calendar year, he/she could face a serious access problem in finding a home that will care for them for free. Let me express my appreciation to Congressmen McCrery and Cardin for their leadership on addressing this problem. Medicare beneficiaries would benefit if Congress would pass HR 1837, legislation introduced by Congressmen McCrery and Cardin. This legislation would address the arbitrary nature of the $1,500 annual caps on Part B outpatient rehabilitation services imposed by the BBA. These caps were included without the benefit of data or hearings. Mr. Chairman, I assure you—speaking from the front lines of the skilled care community, no one who was part of this process could have intended this cap to create the kind of patient impact we're seeing. Mr. McCrery and Mr. Cardin's legislation would create criteria to trigger exceptions to the caps for the sickest and most vulnerable Medicare beneficiaries. Pass the McCrery/Cardin bill (H.R. 1837) to allow for some exceptions for these caps. These caps have reduced a benefit to Medicare beneficiaries and any relief would go a long way to ensure them an appropriate level of benefits.

Mr. Chairman, the bottom line is that the deep cuts in Medicare create a clear and present danger to the well-being of our nation's elderly. The problems are critical and require immediate attention. I would like to outline what we believe to be fair solutions to four critical challenges—solutions that take into account the constraints of Congress and HCFA in implementing change.

Recommendations

1. Create payment add-ons for certain RUG categories effective October 1, 1999. Congress, HCFA and MedPAC all recognize that the new payment system for SNFs fails to account for the costs associated with caring for certain Medicare beneficiaries with medically complex conditions. That is especially true for patients with high utilization of non-therapy ancillary services, such as prescription drugs, respiratory care, IV antibiotics and chemotherapy. To help solve this problem, AHCA supports Senate Bill 1500, the Medicare Beneficiary Access to Quality Nursing Home Care Act. Currently, there is no House companion, but we hope the House will consider similar legislation. S. 1500 would identify where there are patients with high-cost, intense Medicare needs, which are covered in the PPS system and make payment add-ons to address the disparity between the cost of providing those services and the resources Medicare currently provides. Let me briefly address an issue that has raised some questions among policy makers. The RUGs system for

SNFs has never appropriately taken into account non-therapy ancillary services. There has been a great deal of discussion around the RUG categories which are creating the most significant problems. Our research shows that the elderly population we serve is likely to suffer from co-morbidities. In other words, although patients require rehabilitative therapy, it is highly possible—even likely—that many of those patients will have other medically complex needs in addition to that therapy. And that, Mr. Chairman, is the fundamental flaw of RUGs. In the hierarchical RUG system, a patient's rehabilitation needs are often the only criteria by which a patient is assigned a RUG category—often ignoring other expensive life-saving medical services. We recommend targeting a payment add-on to those RUG categories with the highest concentrations of high non-therapy ancillary users. And we recommend that the majority of these relief funds must come in the first couple years so that relief is immediate and lasting.

2. Update the current SNF market basket effective October 1, 1999. To a certain extent also addressed by S. 1500, is the fact that HCFA and Congress should replace the current inflation rate update factor for SNFs with a more accurate measurement of the cost of services they are required to provide. This current market basket grossly understates the actual market conditions for SNFs because it understates the annual change in the costs of providing an appropriate mix of goods and services produced by SNFs. SNFs have dramatically changed the services we provide and the acuity levels of the patients we care for. Mr. Chairman, for some time you have made it clear that the Administration should do its part in refining the system. We have shown in two legal opinions, including one from a former HCFA general counsel, that HCFA has the legal authority to address the inequities of the SNF market basket. In fact, we did this at the request of the White House. I would like to submit both of these legal opinions as an addendum to my testimony.

3. Allow providers to transition to the federal rate effective October 1, 1999. PPS rates are based on cost reports that date all the way back to 1995. We believe providers should have the option of electing to move to the full federal rate immediately if they can show they are disadvantaged by the transition. This would prevent facilities that changed the type and volume of Medicare services after 1995—the PPS base year—from being disadvantaged by the transition rate. Again, this is a matter of equity, and a means of easing the transition to PPS. We believe this can be done administratively by HCFA, however HCFA's intransigence may require Congress to act.

4. Medicare beneficiaries would achieve great relief if Congress would pass H.R. 1837, legislation introduced by Congressmen McCrery and Cardin. Let me, again, express my sincere appreciation to them for their leadership on this.

Mr. Chairman, as I conclude my remarks, I would like to convey to the Committee that we understand that we must work within the constraints that exist. That is why we've worked so hard to put forward solutions that are realistic, reasonable, responsible and within reach. Each of the actions we recommend would restore funding that would ensure continued quality and access to care for Medicare beneficiaries. And that is why each of the actions we recommend today should be adopted for the sake of the patients entrusted to our care. These solutions can only be achieved in a bipartisan fashion, and we look to your leadership.

Mr. Chairman, I thank you for the opportunity to be here today. I proudly entered this noble profession 30 years ago. There are tens of thousands of people such as me out there, and they are hurting. I can honestly tell you—despite the sensationalistic and rare examples of poor performers you see in the media from time-to-time—that an overwhelming majority of my colleagues share the same passion and commitment to this profession, and provide good, quality care. The majority of my residents are rich with love of family, love of life, and have served this country in extraordinary ways throughout their lifetime. It is a privilege to serve them.

On behalf of AHCA, I want to make clear our commitment to providing high quality care to America's frail and elderly. The situation we are facing is critical, but it will get worse unless Congress and the Administration work with providers to fix the system. You can make a very real difference for a population that expects—that deserves—no less. Only you have the power make a difference . . . to give voice to a population that needs your help . . . your nation's elderly, disabled, and the men and women who they rely on every day for their skilled nursing care.

And thank you for the opportunity you have given me today.

Chairman THOMAS. Ms. Bataillon.

STATEMENT OF PAMELA BATAILLON, VICE PRESIDENT, BUSINESS DEVELOPMENT, VISITING NURSE ASSOCIATION OF THE MIDLANDS, OMAHA, NEBRASKA, ON BEHALF OF VISITING NURSE ASSOCIATIONS OF AMERICA

Ms. BATAILLON. Thank you, Mr. Chairman. My name is Pam Bataillon and I am vice president of the Visiting Nurse Association of the Midlands which is located in Omaha, Nebraska. The Visiting Nurse Associations of America are grateful to you and the Committee for your continued interest in refining provisions of the Balanced Budget Act of 1997.

VNAs want to work with you to find administrative and legislative solutions to the problem areas such as the immediate need to address our cash flow crisis resulting from the multitude of Federal regulatory requirements that have been uniformly applied to all the providers, regardless of their history of compliance and responsibility in the Medicare program.

Focused medical review, Operation Restore Trust and Wedge audits, increased technical denials, recoupment of overpayments made under the interim payment system, OASIS, 15-minute incremental reporting and subsequent changes in billing procedures, and now confusing advance beneficiary notices have all come into effect since the passage of the BBA.

VNAA believes that implementation of many of these provisions has gone beyond congressional intent and made it difficult for VNAs and other home care providers to meet the health needs of eligible patients. The compounded effect of trying to simultaneously meet all of these regulatory mandates and survive under low IPS reimbursement rates has affected how we deliver care to patients, depleted our resources, and impacted our staff morale.

Regarding the IPS cost caps, I want to address Mr. Hash's earlier statement today that providers do not understand the nature of the aggregate per-beneficiary cost limit. We clearly understand that the cap is not a per-patient cap and is applied in the aggregate. The problem in terms of meeting patients' needs is balancing all of their costs under the aggregate cap. It does not take very many high acuity patients to upset the apple cart.

As cost-efficient providers, VNAs' aggregate caps are so low that we are finding it very difficult to serve the sickest of patients, which has been our mission for over 100 years.

VNAA understands that Congress had to enact dramatic changes to the Medicare home health program in 1997, but now is the time to reassess and make adjustments so that responsible providers do not continue to be penalized by the IPS reimbursement structure and a one-size-fits-all Federal regulatory mandate process.

We are at the point where we have to make sure that the baby is not thrown out with the bath water, which is why VNAA urges you to ensure that the BBA provision to reduce Medicare home health expenditures by 15 percent never goes into effect. The 15-percent cut is a significant threat to VNAs and to their ability to provide patient care. The average 25 percent budget cuts that VNAs have already made to survive under IPS is challenging our

ability to provide the care that patients need to remain stable and at home. Many VNAs report that they cannot accept all eligible patients because of shortage of staff or anticipated costs. As a group of providers whose costs have been, by and large, under the national average, we have cut into the bone and can't cut any further.

To understand the devastation to my agency from the combined effect of IPS and regulatory mandates, I have included specific information about our agency. Between August 1997 and August 1999, we have had to reduce our budget by $2,600,000, reduce our staff by 42 percent and reduce our total volume of visits by 32 percent.

The result of these budget cuts has directly affected patient care. We have only been able to provide the bare minimum of service, barely getting them to a stable situation before we can dismiss them.

Dismissing patients earlier: more and more we see evidence that this earlier discharge results in hospital readmissions. This creates increased costs for Medicare both at the hospital level and then when the patient is once again referred for post-acute hospital home care, often at a higher acuity level.

The VNA has survived current cuts; however, we have exhausted our resources. A 15-percent cut in revenues would decimate the agency and preclude us from carrying on our 103-year-old mission of providing home health care in our community.

VNAA is certain that another 15-percent cut under IPS would be the straw that would break the camel's back. In response to a survey sent to VNA members earlier this month the vast majority of those VNAs who responded said they would seriously consider discontinuing participation in the Medicare program. Fourteen VNAs said they would definitely or likely close, in addition to the 10 that have already closed due to IPS. All who responded to surveys said they would eliminate or decrease all indigent care and completely deplete their reserves or charity funds and foundation resources.

In most communities the VNA is the choice of last resort, the place that all other home care agencies refer their high acuity and highly complex hard-to-serve patients. Our recommendations are several. They are detailed in the submitted written testimony.

One that would help us would be to ensure that the BBA provision of a 15-percent reduction in Medicare home health expenditures does not go into effect.

Another would be to enable agencies to be reimbursed immediately through a pass-through on their cost reports for the cost of OASIS (which, by the way, has added 30 minutes to a home visit) and other regs.

Another would be to pass legislation to extend the PIP system through at least the first year of PPS system.

Another, exclude home health agencies in good standing from prepayment review and limit their post-payment review to no more than 10 percent of claims.

Also, to increase the per-beneficiary cost limit and the per-visit cost limit to help offset the costs of OASIS implementation.

To implement MedPAC's outlier recommendation under IPS and to enforce HCFA's statement that it will grant 3-year extended re-

payment plans on IPS-related overpayments to home health agencies.

Thank you very much for allowing us to present this information and recommendations to you and your committee.

Chairman THOMAS. Thank you very much, Ms. Bataillon, and we appreciate the specificity and the reasonableness of your request.

[The prepared statement follows:]

Statement of Pamela Bataillon, Vice President, Business Development, Visiting Nurse Association of the Midlands, Omaha, Nebraska, on behalf of Visiting Nurse Associations of America

INTRODUCTION

Mr. Chairman and Members of the Subcommittee: My name is Pam Bataillon and I am Vice President of the Visiting Nurse Association (VNA) of the Midlands, which is located in Omaha, Nebraska. The VNA is an independent, Medicare-certified home health agency serving eastern Nebraska and Western Iowa. I am pleased to be here today to present the recommendations of the Visiting Nurse Associations of America (VNAA) regarding refinements to the Medicare home health provisions included in the Balanced Budget Act of 1997 (P.L. 105–33). VNAA is the national membership association for non-profit, community-based home health agencies.

VNAA is grateful to you, Mr. Chairman and members of the Subcommittee, for your continued interest in refining provisions of the Balanced Budget Act of 1997 (BBA). We support your efforts to ensure that this landmark legislation accomplishes congressional intent and does not inadvertently create federal policies and requirements that are counterproductive to its goals.

Visiting Nurse Agencies (VNAs) want to work with you to find administrative and legislative solutions to the problem areas, such as the multitude of federal regulatory/administrative requirements that have been uniformly applied to all providers regardless of their history of compliance, cost-consciousness and responsibility in the Medicare program. We think it is absurd that providers with nearly 35 years of experience providing quality, cost-effective care in the Medicare program with 0–3% denial rates (and decades of experience before Medicare was established) have to spend more time now responding to the scrutiny of several government audits and complying with paperwork mandates than providing patient care, *or* filling out forms to account for every minute of in-home patient care, *or spending tens to hundreds of thousands of dollars on software and training to meet OASIS requirements that are only reimbursed a fraction of the cost.*

Focused medical review, Operation Restore Trust (ORT) and Wedge audits, increased technical denials, sequential billing, recoupment of overpayments made under the Interim Payment System (IPS), OASIS, 15-minute incremental reporting and subsequent changes in billing procedures, surety bonds, and now advance beneficiary notices, have all come into effect since the passage of the BBA. In addition, HCFA is redefining the benefit, which has created confusion regarding what is and what is not a covered service. For example, providers were given no notification that insulin-management for blind diabetic patients is no longer covered. We have received retroactive denials on such cases.

VNAA believes that implementation of many of these provisions has gone beyond congressional intent and made it difficult for VNAs and other home care providers to meet the health care needs of eligible patients, primarily because of cost and cash flow issues. The compounded effect of trying to simultaneously meet all of these regulatory mandates and survive under low IPS reimbursement rates has depleted our resources and our staff morale. Because of our century-old mission to provide cost-efficient, compassionate care to all patients in need of home health care regardless of condition or ability to pay, we will not let this difficult regulatory period defeat our ability to care for patients—but we need your help.

VNAA understands that Congress had to enact dramatic changes to the Medicare home health program in 1997 and that bold initiatives were required to rid the program of fraud and abuse, but now is the time to reassess and make adjustments so that the responsible providers do not continue to be penalized by the IPS reimbursement structure and one-size-fits-all federal regulatory mandates. We believe that adjustments to the BBA can put us back on the right track before it is too late. We are at the point where we have to make sure that the "baby is not thrown out with the bathwater," which is why VNAA urges you to ensure that the BBA provision to reduce Medicare home health expenditures by 15 percent never goes into effect.

Mr. Chairman, and members of the Subcommittee, you have taken the lead to ensure that the BBA is good, sound policy. We are grateful to you for spearheading legislation last year that made changes to the IPS reimbursement formula, which was the first step toward removing the IPS penalty on cost-efficiency. We know that you will continue to do the right thing by building on the Medicare home health improvements made by last year's Omnibus Appropriations Act. Please repeal the pending 15 percent cut to Medicare home health expenditures, which is scheduled for October 1, 2000. It remains as a significant threat to VNA patient care. The average 25% budget cuts that VNAs have already made to survive under IPS is challenging our ability to provide the care that patients need to remain stable and at home. Many VNAs report that they must discharge patients earlier than the optimal time for discharge. Others report that they cannot accept all eligible patients because of shortage in staff or anticipated costs.

Already, the number of patients who have had to remain in hospitals or nursing homes longer than necessary is increasing. The number of individuals who have had to go without care has also increased. Several VNAs no longer participate in the Medicare program; approximately 10 VNAs have closed; and many have discontinued service in rural areas. Our experience closely parallels the findings of the Medicare Payment Advisory Commission (MedPAC). According to MedPAC's June 1999 report, nearly 40 percent of agencies surveyed responded that because of the IPS, they no longer admit all Medicare patients whom they would have admitted previously, and about 30 percent of agencies reported discharging certain Medicare patients because of the IPS. The Commission suggests allowing agencies to exclude a small portion of their patients from the aggregate per-beneficiary payment limits to ensure that these beneficiaries will have access to needed services.

As a group of providers whose costs have been by and large under the national average, we have cut into the bone and we can't cut any further. To understand the devastation to the VNA of the Midlands from the combined effect of IPS and regulatory mandates, I have included specific information about our agency below.

Between August 1997 and August 1999, we have had to:

- Reduce our budget by $2,600,000;
- Reduce our staff by 42%; and
- Reduce our total volume of visits by 32%.

In 1997, we were 11% under our cost caps. In 1998, we were 12% over cost caps. These actions have resulted in a 32% drop in revenues and a 42% drop in net assets (from $1,595,231 to $973,875). Regulatory mandates, including OASIS, ORT audits, and the 15-minute reporting and billing requirement, have simultaneously added to the pressure of keeping costs under the per-visit cost limits and have increased our average cost per visit from $62.50 to $68.98. This has been a common experience among VNAs, where they have historically kept costs significantly below the per-visit cost limits, and are for the first time just under, at, or above those limits. (Please see VNA of St. Lucie and Martin Counties' data sheet on such costs, which is attached to this testimony).

The VNA of the Midlands was the target of a Operation Restore Trust (ORT) survey in 1999 because we are the biggest home care agency in Omaha. The results of the survey revealed that two nursing visits and one occupational therapy visit on two separate patients were determined to be technical denials because the physician did not date his signature and the date did not appear in locator 23 on the recertification form. Two nursing visits from two different patients were denied because the physician diagnosis of a legally blind diabetic was not deemed sufficient rationale for the VNA to prefill the insulin syringes for the patient. We were cited for not having documented that the family was unwilling to complete the task. The one occupational therapy sample was extrapolated to all the occupational therapy claims for that time period. This meant that the reviewer applied a 9.5% denial rate to all nursing claims a 100% denial rate to occupational therapy claims. Instead of having to repay $322.55 on the actual denied claims, we were subject to a projected overpayment of $24,255.76.

The result of these budget cuts has directly affected patient care. We have only been able to provide the bare minimum service to each patient, dismissing them earlier. More and more, we see evidence that this earlier discharge results in hospital re-admissions. This creates increased costs for Medicare, both at the hospital level and then when the patient is (once again) referred for post-hospital home care, often at a higher acuity level.

The VNA has survived the current cuts; however, we have exhausted our resources. A 15% cut in revenues would decimate the agency. We would seriously consider dropping out of the Medicare program because it could bankrupt the agency and prevent us from carrying out our 103-year-old mission of serving the sick and the poor in Omaha.

VNAA is certain that another 15% cut under IPS would be the straw that would break the camel's back. In response to a VNAA survey sent to member VNAs this month, the vast majority of those VNAs who responded said that they would seriously consider discontinuing participation in the Medicare program if a 15% cut were implemented on October 1, 2000.

The following VNAs who have said they would definitely or likely close are:

VNA of the Midlands in Omaha, Nebraska;
VNA in Princeton, Illinois;
VNA in Plainville, Connecticut;
VNA in Manhattan, Kansas;
VNA in Waterford, Michigan;
VNA is Pittsburgh, Pennsylvania;
VNA of South Portland, Maine;
VNA in Atlanta, Georgia;
VNA in Stuart, Florida;
VNA in Columbus, Ohio;
VNA in Ventura, California,
Sun Home Health Services in Northumberland, Pennsylvania
Home Nursing Agency in Altoona, Pennsylvania

All who responded to the survey said they would eliminate or decrease all indigent care and completely deplete their reserves/charity funds and foundation resources.

VNAA's Recommendations

1. *Ensure that the BBA provision of a 15% reduction in Medicare home health expenditures never goes into effect. We strongly oppose a reduction of the 15% to a lesser percentage, and recommend another delay if necessary before a full repeal can be accomplished.*

We understand that repeal of the 15% cut costs approximately $15 billion over 10 years, according to the Congressional Budget Office (CBO). Because CBO anticipates that Medicare home health savings will be well above the $16.2 billion required by the BBA over a five year period (possibly three-times that number), the 15% cut is not necessary and, frankly, is overkill. If federal budgetary caps make it impossible to repeal the 15% in 1999, then a delay is essential so that the 15% doesn't take effect on the same date as the implementation of the Medicare Home Health Prospective Payment System (PPS)—October 1, 2000. VNAA believes that the PPS is our best hope for a fair and equitable reimbursement system, which will base payments based on the condition of the patient rather than on agencies' historical costs as is the case under the current IPS method. We know that this Subcommittee urgently waits for implementation of PPS. A 15% cut on the date of implementation may doom the plan before it even gets off the ground.

2. Ensure that HCFA's PPS plan is implemented on time and without a transition period. We strongly support HCFA's proposed use of national cost averages in the determination of per-episode reimbursement rates; and urge you to oppose any attempt to transition in the plan using agency-specific historical costs.

3. Pass legislation to extend the Periodic Interim Payment (PIP) system through at least the first year of prospective payment. Extension of PIP would ease the transition from IPS to PPS and has been proven to be critical in terms of cash flow for VNAs under the HCFA PPS Per-Episode Demonstration Project.

4. Sunset the 15-minute increment reporting requirement. This activity has been expensive because of the change in forms and software, and is consuming of a clinician's time in a patient's home. It also does not account for off-site activities performed by the clinician that are directly related to patient care (e.g., physician consultation). An alternative approach that would provide more useful information regarding clinician time and patient outcomes would be to have agencies report "time in" and "time out" and link such information to the patient's OASIS data.

5. Delay the implementation of the New Advance Beneficiary Notice. Although we are supportive of notices to beneficiaries, providers only received directions from HCFA on September 22 for an implementation date of October 1. In addition, the current notices supplied by fiscal intermediaries to providers are lengthy and confusing at best for beneficiaries.

6. Repeal the BBA requirement to bundle durable medical equipment (DME) costs with other home health costs through consolidated billing under the Medicare home health prospective payment system. VNAs view the bundling of the DME into the home health billing process as one additional administrative burden for which there is no cost recognition.

7. Enact a provision contained in H.R. 2456 that would: (1) exclude home health agencies with a finalized claim denial rate of less than 5 percent (average of the

three most recent cost reporting periods) from prepayment review and (2) limit their post-payment review to no more than 10 percent of claims. Conducting high cost, intense audits on all agencies, regardless of past practices by the agency, is expensive and unproductive. Matching the rate of review to the rate of denial would provide an incentive to agencies to submit "good claims" because it would result in less review.

8. Enact a provision in H.R. 2240 that would further increase the per-beneficiary cost limit for home health agencies whose current PBLs are currently under the national average PBL. An increase in the PBL for these agencies would better enable them to serve the highest-cost patients and help offset the costs of OASIS implementation.

9. Increase the per-visit cost limit to help offset the costs of OASIS implementation.

10. Implement MedPAC's outlier recommendation under the Interim Payment System.

CONCLUSION

VNAs' sole purpose for participating in Medicare is to provide compassionate, cost-effective care to patients. If regulations strangle our ability to meet patients needs and if low reimbursement does not cover the cost of care, more responsible providers will make the decision to drop out of the Medicare program. Mr. Chairman, the loss of good, responsible providers is not what the Medicare program needs. We have kept costs down. We are often the providers of last resort. We have helped families cope with disability and death in the comfort of their own homes for over 100 years. Please enact and enforce our recommendations to ensure that responsible home care providers can continue to serve Medicare beneficiaries for another 100 years. Thank you for allowing us this opportunity to provide our views and recommendations.

[Attachments are being retained in the Committee files.]

Chairman THOMAS. Ms. Swigert.

STATEMENT OF NANCY B. SWIGERT, OWNER, SWIGERT AND ASSOCIATES, INC., LEXINGTON, KENTUCKY; AND IMMEDIATE PAST PRESIDENT, AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Ms. SWIGERT. Thank you, Chairman Thomas and Members of the Subcommittee, for allowing me to appear here today.

My name is Nancy Swigert and I have a private practice in Kentucky. As a practicing speech-language pathologist, I teach people who have had a stroke to learn to swallow again. If they can't learn to swallow again, the consequences are for food and liquid to get in the lungs, causing pneumonia or death. In fact, more deaths result from asphyxiation following stroke than any other complications.

I also work with patients who can't communicate, and teach them how to communicate again. Lack of communication skills results in patients needing more expensive, and more intensive levels of care.

I am before you today as the immediate past president of the American Speech-Language-Hearing Association. We have close to 100,000 speech-language pathologists, audiologists, and speech-language-hearing scientists. We work very closely as well with other professional rehabilitation organizations like the American Occupational Therapy Association and the American Physical Therapy Association on issues that we are discussing in the hearing today.

Therefore, I am here today representing a total of approximately 300,000 rehabilitation therapy professionals.

As the Committee considers BBA refinements, ASHA urges the committee to include provisions that would relate to outpatient rehabilitation services. We ask that you consider both enactment of an exceptions process that retains the caps, except in those instances where the patient requires medically-needed services, and incorporating three $1,500 caps by granting independent status for speech-language pathologists.

As the cap is currently implemented by HCFA, the burden of the utilization policy is being borne chiefly by high acuity patients. It seems that the patients who are going to exceed the cap are those who have multiple diagnoses, or those who have multiple incidents within a year. And we have to remember as well, that patients in nursing homes can't switch providers when they have reached their cap.

To make matters worse, in implementing this provision, the Health Care Finance Administration ruled that speech-language pathology and physical therapy share a $1,500 cap.

Mr. Chairman, we have appreciated your personal efforts to try to correct that situation administratively, but in the absence of action by the agency, we urge the Committee to legislatively make the technical corrections necessary to resolve this unintended consequence of the BBA. While I can provide the committee with case after case of real-life examples even within my own family of how Medicare beneficiaries' lives have been changed negatively, I would like to share with you a summary of a recently completed randomized survey of speech-language pathologists who reside in Texas, North Carolina, Connecticut and California. In brief, clinicians estimated that 23 percent of patients covered by part A and 70 percent of patients covered by part B were expected to be denied speech-language pathology services due to restrictions directly resulting from the BBA policy changes.

According to clinicians, the most frequently cited consequence of denied care was the potential for an increased risk of aspiration pneumonia, which is getting food and liquid in the lungs, and dehydration. Let me point out, by the way, that treatment of aspiration pneumonia costs on average about $15,000, so the therapy to prevent it is a real bargain.

Mr. Chairman, I believe that this study confirms our most grave concerns about the negative impact and unintended consequences of some BBA policy decisions. We believe Congress needs to take action now to make reasonable refinements in these policies so that appropriate and necessary care to our seniors is not sacrificed. I would ask you, Mr. Chairman and Members of the Subcommittee, to consider two specific options that Congress can implement to that end.

First, as sponsored by a number of Members of this Committee and specifically initial cosponsors Congressmen McCrery and Cardin, enact the Burr-Grassley legislation, H.R. 1837, that retains the cap except in those instances where the patient requires medically-needed services.

Second, recognize the independent services being provided by speech-language pathologists, thereby eliminating the shared cap

between speech and physical therapy. Because of this misdirected interpretation of the BBA therapy cap provision, there needs to be a distinction made as a matter of law and public policy. I urge this Committee to distinguish these types of care and not force a patient to choose whether he or she will be able to walk or swallow again.

Speech-language pathology services are a benefit under current law and have been since 1972. However, as a speech-language pathologist in private practice, I cannot bill directly to Medicare. We are merely asking that you grant us the same level of billing authority as physical and occupational therapists. By function of law this would then extent the current two caps to three caps. We need both the exception process and a delinking of physical and speech therapy.

Mr. Chairman and Members of the Committee, on behalf of ASHA and the other rehabilitation professional groups, we appreciate your efforts to rectify the problems presented by the current therapy caps as well as the opportunity to discuss our views on this critically important matter. We urge you to take action to remedy the unintended consequences caused by the implementation of these arbitrary caps and we look forward to working with Congress and HCFA to fix these problems. Thank you.

[The prepared statement follows:]

Statement of Nancy B. Swigert, Owner, Swigert and Associates, Inc., Lexington, Kentucky, and Immediate Past President, American Speech-Language-Hearing Association

Thank you, Chairman Thomas and Members of the Committee, for allowing me to appear before you today. My name is Nancy Swigert, and I am the owner of a private practice in Kentucky. I personally provide speech-language pathology clinical services, and I am the immediate past president of the American Speech-Language-Hearing Association (ASHA), which represents nearly 100,000 speech-language pathologists, audiologists, and speech, language and hearing scientists. We also work closely with the other national rehabilitation professional organizations—the American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA)—on the issues related to todays hearing; in total representing some 300,000 rehabilitation therapy professionals.

On behalf of these professionals and our patients, we appreciate the opportunity to present our views to this Subcommittee concerning problems in the implementation and refinements to the Medicare provisions in the Balanced Budget Act (BBA) of 1997 impacting services to outpatient rehabilitation beneficiaries. As Congress prepares to consider BBA refinements, ASHA urges inclusion of improvements that relate to outpatient rehabilitation services in any "BBA fix" legislation approved by the Subcommittee, specifically the $1500 beneficiary cap on a combined speech language pathology/physical therapy benefit. This provision, which also includes a separate $1500 cap on outpatient occupational therapy, was enacted to control "inappropriate" utilization of outpatient rehabilitation services by requiring beneficiaries to pay for services that exceed the cap.

However, what this provision has done is disrupt treatment for many and denied seniors, especially those who are the sickest, the necessary services they need so that they can return to functional levels in the most fundamentally human skills of swallowing, speaking and walking. As implemented, the burden of the utilization policy is being born chiefly by high-acuity patients, such as individuals recovering from stroke, hip injuries and medically-complex cases that result in multiple medical incidents within a single year.

In testimony previously given before other congressional hearings on the impact of this policy from the BBA, we believe representatives from federal agencies have trivialized and underestimated the number of Medicare beneficiaries who will exceed the caps, and will consequently face either disrupted and costlier care or denied care. Moreover, it is our strong contention that government assessments about the impact of these caps is significantly under estimated due to the self-rationing by patients and their families, as well as widespread confusion about how this policy has

been implemented. Mr. Chairman and Members of the Committee, I ask that you not to let them play down the severe impact of the caps are having on the hundreds of thousands of our sickest Medicare patients.

To make matters worse, in implementing this provision, the Health Care Financing Administration (HCFA) ruled that the speech-language pathology and physical therapy were to share $1500 for those Medicare outpatients who required both, citing the BBA provision that included speech-language pathology services (SLP) with physical therapy (PT) services. This action set an ugly precedent, disregarding the whole of Medicare and Medicaid regulations developed since 1972, when "speech pathology services" were added as a benefit, as well as all clinical and practice standards that clearly recognize speech-language pathology and physical therapy as separate and very distinct services. Essentially, the 1972 amendment adding speech-language pathology services was re-interpreted to mean that Medicare outpatient speech-language pathology is a part of Medicare outpatient physical therapy, even though there is a separate definition in the statute (Section 1861(ll) of the Social Security Act) for speech-language pathology services. ASHA protested the interpretation and provided HCFA with a legal analysis that, we believe, gives the agency adequate flexibility in correcting this problem. While sympathetic with our case, HCFA has cited that it does not have the authority to make such a change. Mr. Chairman, we have appreciated your personal efforts to administratively correct this situation. But in the absence of action by the agency, we urge the Committee to legislatively make the technical corrections necessary to resolve this unintended consequence of the BBA.

While I could provide the Committee with case after case of real life examples—even within my own family—of how Medicare beneficiaries' lives have been negatively changed, I would like to share with you a summary of a recently completed randomized survey of speech-language pathologists who reside in Texas, North Carolina, Connecticut, and California. The survey investigated the impact of recent changes in Medicare reimbursement policies on the access patients have to the care provided by speech-language pathologists, and the nature of the possible consequences to the well being of these patients if the care is not available.

In brief, clinicians estimated that 23% of patients who were covered under Part A and 70% of the patients covered under Part B were expected to be denied speech-language pathology care due to restrictions directly resulting from BBA policy changes. According to the clinicians, the most frequently cited consequence of denied care was the potential for an increased risk of aspiration pneumonia and dehydration, while also noting that these patients would likely experience an inability to resume normal daily activities and would continue to rely on a caregiver. Mr. Chairman, I believe that this study reconfirms our most grave concerns about the negative impact and unintended consequences of some BBA policy decisions.

We believe Congress needs to take action now to make reasonable refinements in these policies so that appropriate and necessary care to our seniors is not sacrificed. I would ask you, Mr. Chairman, and Members of the Committee, to consider two specific options that Congress can do to this end:

First, as sponsored by a number of Members of the Committee, enact the Burr/Grassley legislation (H.R 1837 and S. 742) that retains the cap except in those instances where the patient needs the additional services. Specifically, if a patient has a dual diagnosis; has two episodes of illness in one year; or is at risk of hospitalization. We worked on this legislation because we understood Congressional wishes to control utilization of this benefit. However, this benefit is intended to improve patient care and exceptions should be made for those patients who need the services and avoid costly inpatient hospitalizations.

Second, separate the shared cap between speech-language pathology and physical therapy services, and recognize in legislation the independent services being provided by speech-language pathologists. Because of misdirected interpretation of the BBA therapy cap provision, there needs to be a distinction made—as a matter of law and public policy—between the offering of speech-language pathology and physical therapy services. As a provider, I treat people who have had strokes relearn to swallow. More deaths result from asphyxiation following a stroke than any other complication. As a provider, I treat people who can not communicate. Relearning these skills is time consuming, especially for a patient who has had a massive stroke or who have Parkinson's Disease. These are services that are very different from physical therapy. I urge this Committee to distinguish these types of care and not force a patient to chose whether he or she will be able to swallow or walk again because of the unintended consequence of this combined cap on SLP and PT services.

Under current law, a speech-language pathologist can provide services as an independent practitioner; however, they must send their bills through either a physical

therapist or a physician. This benefit is in current law. We are merely asking that you establish us with the same level of billing authority as physical and occupational therapists. By function of law, this would then extend the current two caps to three caps. Combining this with the Burr/Grassley legislation allows for two important improvements:

(1) when patients are seriously ill, their care can continue without the beneficiary having to pay out-of-pocket for services;

(2) for other patients seeking therapy services that do not fall into this category, they would have $1500 cap in speech-language pathology services; $1500 in physical therapy services; and $1500 in occupational therapy services.

Mr. Chairman and Members of the Committee, on behalf of ASHA and the other rehabilitation professional groups, we appreciate your efforts to rectify the problems presented by the current therapy caps, as well as the opportunity to discuss our views on this critically important matter. We urge you to take action to remedy the unintended consequences caused by the implementation of these arbitrary caps, and we look forward to working with Congress and HCFA to fix these problems.

Chairman THOMAS. Thank you very much.

The gentleman from Louisiana, does he wish to inquire? I know he has a time constraint.

Mr. MCCRERY. Yes, thank you, Mr. Chairman. I am trying to catch a plane this afternoon.

Sister Keehan, is that how you pronounce your name, Keehan?

Sister KEEHAN. Yes.

Mr. MCCRERY. I was pleased that you pointed out a number of areas where you thought the administration could provide some relief through administrative action. Do you know to what extent the American Hospital Association has pursued those areas with HCFA and what kind of response you have gotten from HCFA?

Sister KEEHAN. I can say very candidly that we have made certain that HCFA and the administration know that these are the areas we want addressed. To my knowledge, we haven't gotten a formal response. I think all of them are under advisement, but we haven't gotten a formal response.

We have made these known as an organization. We have made them known as individual providers. We would like a response, quite frankly. It is October 1.

Mr. MCCRERY. We would, too. Thank you.

Ms. Swigert or Mr. Hendrickson, with respect to the therapy caps, just to give the Subcommittee some sense of the problem, could one of you or both of you describe for us the kind of therapy that, say, a stroke patient would need, and how much that therapy would cost in relation to the caps?

Ms. SWIGERT. I think I could do most of that, except I am not sure about the cost. I will see if somebody can help me.

It is a very good diagnosis, as an example, because almost every patient who has a stroke needs all three therapies.

Physical therapy works on bed mobility, helping the patient learn to sit, balance again, hopefully to walk, or at least be mobile in a wheelchair.

Occupational therapy helps that patient learn to care for themselves again, to be able to brush their teeth, comb their hair, and dress, so they are not totally dependent on a caregiver.

Of course, they are also going to need a lot of therapy for both swallowing and communication. They need a lot of intensive therapy, and certainly at least what the speech/language pathologist

can address typically for a stroke patient is definitely going to exceed the $1,500 cap.

Mr. MCCRERY. Would you like to add to that, Mr. Henderson?

Mr. HENDRICKSON. I can add to that in that certainly stroke is a wonderful example of where patients are going to continually come up against the cap.

The stay under A for a stroke is normally a short period of time, and normally the real rehabilitation time takes place under B. In the case of most stroke victims, they would cap without question under just simple rehabilitation of getting over the condition. So that is a very excellent choice of medical conditions, but most of them would be against the cap, almost without question.

Mr. MCCRERY. Mr. Hendrickson, you noted that changes in Medicare cut your reimbursement for medically complex patients from $408 to $231 per day. Have you estimated your actual costs for providing the level of service necessary for those medically complex patients?

Mr. HENDRICKSON. Certainly we have, and it is considerably higher than $231 a day, I will assure you of that.

I am glad you asked me the question, because we in our case were affected by a double hit and probably an unintended consequence of BBA. Being a facility who took over in 1997 with no Medicare, the base period for that facility was very, very low, so we find ourselves providing services today under a 25 percent implementation of PPS at $65 a day less than the national average PPS rate. So we not only have the problem of having high-intensity patients receive less money, but, because of the base period, we are disadvantaged with another $70 or $65 a day below the Federal rate.

But our costs to provide care to a patient like that would be very, very comfortably in the range of about $300 to $310 a day.

Mr. MCCRERY. Thank you, all of you, on the panel. I appreciate your testimony.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. I also thank you for your testimony.

We have a relatively limited objective in the attempt to put this legislation together. I know it is a difficult job representing your own particular interests, notwithstanding the fact you are speaking for a larger group, and you have in front of you the statements that the larger group wants you to make. You are trying to get your position represented, as well. But it is not real helpful for us in the kind of decisions that we need to make when some of the testimony is reflected.

For example, Mr. Hendrickson, and I am glad you got into that exchange with my colleague from Louisiana, I believe your statement was, if funding is not restored. We are not going back to pre-BBA. The idea that the position is to simply abolish provisions makes it very difficult, because, in essence, you are throwing yourself at the mercy of the Congress to pick what it is we are going to do for you.

To the degree that you can, provide specific areas in which we can make some adjustments, or, as Dr. Corlin, utilize the Med-Pac recommendations, which I think go right to the particular subject

matter. And we are going to be, obviously, looking at those very carefully. There may be some disagreement over percentages or timelines, but the areas that have been emphasized are areas that we can go to.

Sister Keehan, in your testimony I heard that you wanted or you read that you wanted a floor or a stop loss. I don't recall the statement of a delay. That obviously would have an impact in which we don't impose it in the timeframe that was indicated and that we buy some time or we stretch it out.

Sister KEEHAN. That was the opening sentence, Mr. Chairman.

Chairman THOMAS. I apologize, then.

Sister KEEHAN. It should reverse its decisions to cut outpatient payments. That is, until it can get to—AHA has been supportive of a new method of payment, but even Med-Pac and everybody today has said how terrible the data is. You don't go to a new method of payment with such flawed data, and everybody admits it. We are saying hold it until you get good data.

Chairman THOMAS. The idea that it has to be a dollar amount may be difficult in certain instances. Your best chance is to give us as many specific items so we can kind of pick and choose.

Ms. Bataillon, you did that, and I know that you emphasize, because it is a fairly large sword hanging over your head, the 15 percent cut. But that is not scheduled to go in until October 1, 2000. That is, for us, a fiscal year away.

You suggested a number of specifics. I am going to be looking at those, things such as we know there is an enormous disparity between States that get high payments and low payments. We have created a kind of a blend structure that will move to a national average.

I think it would be beneficial, because you are one of those areas that have a low utilization, that you can, in fact, move to the national average immediately, rather than waiting for the phase-in.

Obviously, those above the national average are going to want as long a glide slope as possible, but it seems to me that, for the dollar amounts and to get assistance where it is most needed, we ought to be able to allow those that are below the national average to move to the national average. Those are the kinds of things that we can do.

Ms. Swigert, the idea of reopening, creating the three caps, makes some sense. I know my colleague from Maryland and my colleague from Louisiana are talking about a diagnosis-related payment structure. We may, in the time we are dealing with it, instead of trying to create that structure, we might perhaps at least at this stage create an outlier for a percentage of the really high costs, whatever they may be, and rather than pinning them in particular categories, getting those out from under the cap, where they are relatively few and very expensive, and then take another look at it.

As I had said earlier, and I know you folks have been kind enough to stay here all day, this is going to be something we are going to be doing periodically. It is especially difficult because HCFA, in its commitment to all these measuring tools, as soon as the law was passed, turned around and said, we cannot produce them in the timeframe that we need them.

We plugged some numbers in. The $1,500 cap was an ASLHA number. Combining the cap was arbitrary. We were trying to get a handle on it. That may work for 6 or 9 months, certainly not for 2 or 3 years.

So as you present information, go back over your testimony, talk to your principals, I would say that if you have a list of specific doables, and you believe them to be doable, fairly specific, you have a better chance of getting into the package that makes adjustments relatively quickly, rather than talking about long-term programs that will redirect the Balanced Budget Act. That will occur over time as the data comes in, but I will repeat myself, the more specific, the more easily we can make the change, the better chance you have.

Obviously, you want to do some money adjustments. Those can be in there, but the dollar amount that we have, just look across the dais here in terms of the broad-based interests that you represent and the dollar amounts that we have available.

That is why at the beginning of the hearing I said we needed to deal with real costs, where they need to go, and short time lines. It doesn't do any good for us to offer you some relief in 2004 if you are not going to be around. And, frankly, Ms. Bataillon, given the history of the VNA, your willingness to provide care for those who otherwise would not get it has a significant impact on me when your poll shows that people who are there because their heart and souls are there are not going to be able to continue.

We need to make some immediate fixes and then pick up our heads and talk about where we need to go over the next several years, and we will walk ourselves through this adjustment period. There is no question that the regs do not reflect the acuity that we need. You have heard the testimony. HCFA said it cannot adjust, we cannot create new regs, but we are going to work on identifying the acuity areas so we can get money in those areas that most appropriately need it, so that patients do not get turned away or get denied needed coverage.

But it is not especially helpful if the immediate response is, these are the resource utilization groups we want increased, and all of them are rehab. That does not necessarily reflect the acuity that we are looking for.

You need to understand, we have a relatively short time line. The more specificity you give me, the more choices I have available, the better the opportunity we can provide you with immediate fixes to get us through this period so that HCFA computers are up and running again and that we are getting data coming in so we can make additional adjustments.

This is an ongoing process which, hopefully, continues to lead upward, upward in terms of better programs, a little more money, better information and better utilization of taxpayers dollars.

I want to thank you very much for your willingness to wait through the day and to provide us with excellent testimony, but as much specificity as you can give us would be much appreciated.

Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Let me thank the panel for their testimony and for their patience.

The issues that you have raised we have been questioning during the course of this hearing. I agree with the chairman. I hope we will be able to come up with some solutions during this session.

Sister Keehan raised an issue I want to underscore, graduate medical education. We have not had too much discussion about that during this hearing. I would just remind the chairman that I do have a bill in on graduate medical education that not only deals with the problems our academic centers have but we give the chairman about $6 billion over 5 years that he could use if he needed some additional revenue.

I also like to make—he asked for some specific suggestions. I thought we should put that one on the table.

Thank you all again for your testimony.

Chairman THOMAS. I would tell the gentleman who represents Johns Hopkins——

Mr. CARDIN. The University of Maryland, also.

Chairman THOMAS [continuing]. And the University of Maryland that the system that has historically sustained graduate medical education in this country simply on the backs of the hospitals, and especially the Medicare payments, is a system that cannot be sustained. You have been very creative in looking for additional ways to fund it. Unfortunately, some of those who are directly representative of those institutions have only recently begun to understand that they have to come forward, just as these individuals have, with very specific, programmatic changes. We need the doable and not the desirable. Hopefully, what you have given us is primarily doable and moves us in the direction of the desirable.

Thank you very much. The hearing stands adjourned.

[Whereupon, at 3:05 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of the American Academy of Family Physicians

The 88,000 members of the American Academy of Family Physicians would like to provide the following comments on the impact of the Balanced Budget Act of 1997 (BBA) on graduate medical education. Included in this statement are the specific problems with the Act and the Academy's recommendations for solving them. All of the relief the Academy seeks can be achieved in the provisions of the Graduate Medical Education Technical Amendments Act of 1998 (HR 1222), and we urge you to include this bill in any legislation you craft to remedy problems with the BBA. We are pleased that the House Ways and Means Subcommittee on Health is reviewing how this significant law is impacting important programs.

BACKGROUND

The Academy has had a long-standing interest in graduate medical education because of our commitment to a rational physician workforce policy that both discourages an oversupply of physicians, and encourages increased training of those physician specialties in short supply. Our organization has produced and updated regularly a number of policies on physician workforce issues, as well as specific GME recommendations. Recently, the Academy undertook a year long process to revise our physician workforce recommendations with the goal of supporting efforts to ensure that all Americans have access to primary care services; that the needs of underserved rural and urban populations are met; and that evolving managed care delivery systems have an adequate supply of an appropriate mix of primary care physicians.

In addition, the Academy has long been concerned that graduate medical education in the US is currently financed by the Medicare program without sufficient incentives to reduce the oversupply of physicians or ensure appropriate distribution of physicians by geographic location and specialty. Although there are several harmful consequences as the result of this disconnect between Medicare policy and physi-

cian workforce needs, one of our primary concerns is the imbalance between primary care and subspecialist physicians in this country.

Changes Necessary as a Result of the Balanced Budget Act of 1997

In general, the Balanced Budget Act of 1997 contains several graduate medical education policies advocated by the Academy for years. The Academy supports a limit on the number of medical residents, and we also support GME payments for training in non-hospital sites and the carve-out of payments to teaching hospitals from the average adjusted per capita cost. However, we have supported these policies in conjunction with specific protections for needed primary care programs. Such protections are absent from the law and regulations. In fact, the only section of the Act that includes an acknowledgment of the importance of primary care training programs is the demonstration project, which allows incentive payments for voluntary reduction in residents. Unfortunately, the Act has had serious consequences for family medicine programs.

Following are recent data on how the BBA has affected family medicine residency programs. The information was obtained by the Academy and the Organizations of Academic Family Medicine.

- The BBA '97 is causing family medicine residency programs to reduce significantly their number of residents for the first time, and to force an unusually high number of programs to close.

(According to the survey, 10% of all family medicine residency programs have been asked to reduce their number of residents due to the BBA, while 23% have been informed it is likely they will have to cut back. This is the first year that programs have been forced to reduce their number of residents; in 1990, there were 380 programs, a figure that increased to 470 in 1998. In addition, at least five programs are expected to close; the number is typically one or two per year. As a result, the BBA has had a serious impact on family medicine residency programs.)

- A major purpose of the BBA was to encourage the growth of rural training programs. Recent data indicates that family medicine rural training "tracks," programs that require residents to spend one year in an urban facility and two years in a rural area, have an exceptional retention rate: 76% of their residents remain in rural areas.

(According to the survey, 29 of the nation's 474 family medicine training programs (1999 figure) have established rural training tracks. Remarkably, every graduate of one-half of the reporting programs was practicing in a rural area, a 100% retention rate. Overall, 76% of the graduated residents were serving rural communities. As a result, these data indicate the success of these family medicine training programs, programs that should be expanded and continued in any BBA "fix" legislation.)

In addition, other harmful effects of the Act are demonstrated in the following results of a survey of family medicine training programs, which was conducted by the Organizations of Academic Family Medicine.

- 56 percent of family medicine programs responding that were in the process of developing new rural training sites have indicated they will either not implement those plans, or are unsure of their sponsoring institutions' continued support.
- The majority of those family medicine programs that are planning to decrease residency slots are the sole residency program in a teaching hospital. (This means these family practice programs have no alternative way of achieving growth such as decreasing other specialty slots within the 1996 cap on positions.)
- Due to significant training out of the hospital, most family medicine residency respondents did not have their full residency positions captured in the 1996 cost reports upon which the reimbursement is based, causing a loss of Medicare revenue compared to most other specialties that train almost exclusively in the hospital.

Recommendation

Following are the Academy's four recommendations for solving these problems. These provisions are included in HR 1222.

Supporting Residency Training in Ambulatory Sites

HR 1222 would treat all hospitals sponsoring residency programs fairly—not just those that were training residents in the hospital in 1996—by including those residents who were training in the community in the cap. This provision would halt the reduction in numbers in family medicine residencies and also stop the closure of these programs.

As you know, the BBA capped the number of residency slots in an institution, a number that determines the amount of indirect graduate medical education funding (IME) the institution receives. Without "resetting" the caps, the residency programs

that were training residents in the community in 1996 will have their Medicare IME cap lowered and receive less funding in subsequent years. Ironically, while one intent of the Act was to encourage ambulatory training by providing IME support after 1998, the Act inadvertently did not account for those residents who were already training outside of the institution at the time, such as family medicine residents. The Academy supports Medicare funding for all residents training outside of the hospital.

Providing Limited Growth to Single Residency Program Hospitals

HR 1222 would allow hospitals that sponsor only one residency program to increase their resident count by one per year, up to a maximum of three, to meet community needs for primary care physicians.

Under the BBA, a hospital with several residency programs can move positions from less popular subspecialty programs to high-demand primary care programs, such as family medicine, to meet the residency caps. By contrast, a hospital with only one program does not have this option. Approximately 300 hospitals sponsor only one residency program; 191 are in family medicine.

Supporting Residency Programs Under Development

HR 1222 bill would allow a few, new, family medicine residency programs that have long been under development to be established by extending the cut-off date for new residencies. Specifically, any residency programs that were approved after January 1, 1995, and before September 30, 1999, could be set up.

The BBA set August 5, 1997, as the cut-off date for new residencies, which had a disproportionate, negative effect on family medicine residency programs because of the growth in these training programs.

Meeting the Needs of Rural Communities

HR 1222 would permit the establishment of new, rural training programs by allowing urban residency programs sponsoring these programs to receive an exception to the caps (for the rural programs only.) As referenced above, these programs have 76% retention rates.

The BBA capped all residency programs, but strongly supported the establishment of rural programs. This provision clarifies the intent of the Act by supporting the growth of rural programs.

CONCLUSION

The American Academy of Family Physicians appreciates the opportunity to inform your deliberations on the impact of the BBA on graduate medical education system. Thank you for the opportunity to provide these comments.

Statement of David S. Holtzman, Esq., Director of Government Affairs, American Association of Diabetes Educators, Chicago, IL

Dear Mr. Chairman and Honorable Members of the Subcommittee: On behalf of the members of the American Association of Diabetes Educators, we appreciate the opportunity to share with you our concerns regarding implementation of the "Expanded Coverage for Outpatient Diabetes Self-Management Training Services." In our view, the promise of substantial expansion of Medicare beneficiary access to outpatient diabetes education training services and the savings to Medicare that would result from reduced long term expenditures for medical care and hospitalizations have gone unfulfilled. Opportunities exist for legislative action by Congress as well as action by the Administration.

The AADE is a professional association comprised of over 11,000 health care professionals nationwide from a variety of disciplines who provide direct patient care to people with diabetes in a variety of settings.

AADE was proud to play a leading role in the development of the landmark legislation directing the Health Care Financing Administration to provide expanded benefits for outpatient diabetes self-management training services through the Medicare program. This comprehensive improvement in access to diabetes self-management education could provide millions of dollars in long-term savings for Medicare and other federal health programs by providing people with diabetes the means and the knowledge to stay healthy and avoid medical complications.

A General Accounting Office report found that at least 1 in 10 Medicare beneficiaries is diagnosed with diabetes and that it is that up to 25 percent of all Medi-

care costs go to treat diabetes or its complications. [Medicare: Most Beneficiaries With Diabetes Do Not Receive Recommended Monitoring Services. GAO/HEHS–97–48, March 1997].

Studies conducted in this country and abroad have shown that if people with diabetes manage their disease through keeping their blood glucose levels within acceptable ranges it can significantly reduce healthcare costs. People with diabetes establish good control over their diabetes by learning how to monitor their blood glucose levels and to lower or maintain good control through a combination of behavior modification, learning the principals of good nutrition, and often medication. People who establish good control over their diabetes can largely avoid the expensive hospitalizations that can result from uncontrolled diabetes and the life threatening complications that result if the disease is not well controlled.

However, the expected savings to the Medicare program have not been realized because the road to implementation of the expanded benefits for the diabetes education benefit has largely gone unfulfilled. HCFA has largely failed to implement the benefit in a timely or coordinated manner. The BBA directed HCFA to implement the expansion of coverage for outpatient diabetes education and training services as of July 1, 1998.

Earlier this year the agency proposed rulemaking attempting to implement the expanded benefit. [Outpatient diabetes self-management training services; expanded coverage. Federal Register, Vol. 64, No. 28, Feb.11, 1999 6827–6852] The proposal was highly controversial and met with almost universal condemnation by providers and patient groups in the diabetes community.

The provisions of the proposed rule were widely criticized as establishing excessively restrictive eligibility qualifications on which seniors with diabetes could receive self-management education along with unrealistic limits on the type of services and the providers to be deemed qualified by HCFA.

AADE is extremely concerned that HCFA's proposal to establish onerous requirements for HCFA-approved providers will dramatically reduce the number of diabetes education programs that are eligible to provide services to Medicare beneficiaries and severely limit access to diabetes education services. HCFA estimates that some 750 "approved entities" will be authorized to provide outpatient self-management training services once the final rule is in place. This is wholly inadequate. Far more diabetes educators will need to participate as Medicare providers in order to meet the goal of the legislation.

The proposed limits on program length and format of the diabetes education also do not provide adequate flexibility to enable Medicare beneficiaries with diabetes to receive the full benefit of this program. HCFA's decision to set the maximum lifetime benefit at 10 hours with a potential of one additional hour per year upon physician's order is inadequate. And, except in exceptional circumstances all patient education must be offered in a group setting. The HCFA proposed patient eligibility requirements for diabetes education fail to recognize that diabetes is a disease that requires constant monitoring and frequent alterations to a patient's treatment and education plan.

Finally, the standards for diabetes education should be formed with the involvement of the diabetes community so that the means used to assure program quality does not become a barrier to access. HCFA's proposal would have the agency be the final arbiter of national standards that are developed by the leading organizations representing patients and providers in the diabetes community.

This controversial HCFA proposal generated a firestorm of criticism including over 1350 comments to the agency during the proposal's 60 day review period letter. Additionally, a letter signed by 117 members of this House urged HCFA to make real and substantive changes to the agency proposal consistent with the concerns raised by AADE and other members of the diabetes community.

In the absence of formal HCFA rulemaking determining the provisions and procedures of the new diabetes benefit, the agency has put into place national coverage policies to guide intermediaries and carriers who process claims submitted by patients and service providers for outpatient services under Part B of the Medicare Program. These "temporary" policies have been in effect for over 15 months.

The national coverage policies put into place are substantially similar to the plan subsequently proposed by HCFA in its February 1999 proposal. As a result the intended expansion of access to quality diabetes self-management education has been stymied because prospective providers cannot meet HCFA's onerous requirements. Further, existing providers are threatened because they too will not be able to meet the burdensome standards proposed by the agency.

The end result is that many Medicare beneficiaries have been blocked from access to the needed diabetes education services that Congress identified as being crucial in reducing the costly expenditures for diabetes and related complications because

HCFA's policies have prevented qualified providers from participating in the Medicare program.

Along with the challenges created by the Administration in implementation of the Expanded Coverage for Outpatient Diabetes Self-Management Training Services, the text of the authorizing legislation has created an obstacle for diabetes educators seeking to provide services to Medicare beneficiaries, effectively preventing the providers uniquely qualified to provide diabetes education services from participating in the Medicare program. We urge the Congress to pass legislation which would permit Certified Diabetes Educators to be eligible as providers of diabetes self-management education and training services to Medicare beneficiaries.

Section 4105 of the BBA expanded Medicare, Part "B" to include coverage for Diabetes Outpatient Self-Management Training Services furnished by a Certified Provider in an outpatient setting; and, by an individual or entity meeting the quality standards established by the Secretary of Health and Human Services.

Section 4105 defines a Certified Provider to be a physician, or an individual or entity that in addition to providing diabetes outpatient self-management training services, provides other items or services payable under the Medicare program. However, very few diabetes educators provide any other service to Medicare. This definition of Certified Provider has effectively prevented diabetes educators from expanding their practices into facilities outside the hospital setting.

The goal of the BBA was to encourage vital and lifesaving diabetes education services to be available to Medicare beneficiaries in delivery systems beyond the walls of the hospital. The tragedy is that the same educator who is providing the services to patients inside the hospital is prevented from participating in the Medicare program when moving the practice setting into the physician's office. While the BBA permits individuals and entities without any prior connection or experience treating people with diabetes to be reimbursed the healthcare professionals with the most expertise cannot be reimbursed.

Including CDEs as a Certified Provider broadens access for Medicare beneficiaries to receive diabetes outpatient self-management training services through health professionals with demonstrated expertise to deliver quality diabetes education services. The health professional holding the CDE credential has met specific and rigorous eligibility criteria, including academic preparation, practice experience and passage of a written examination. There are approximately 10,500 CDEs in the United States, distributed throughout every state. As a group, CDEs are comprised of health professionals trained in many disciplines including registered nurses, registered dietitians, registered pharmacists and physicians. Recertification of the credential is required every 5 years. No other provider group, individual or entity currently recognized as a Certified Provider meets this standard.

Our members respectfully urge the Committee to impress upon the Administration the need for swift and decisive action by HCFA to implement the Expanded Coverage for Outpatient Diabetes Self-Management Training Services consistent with the recommendations made by this organization and the other organizations within the diabetes community. Further, we urgently request that Congress pass corrective legislation to amend section 4105 of the BBA to permit Certified Diabetes Educators to participate as providers in the Medicare program.

We thank Chairman Thomas and the members of the Subcommittee for their leadership and support of quality diabetes care. We look forward to working closely with the members and their staff in finding solutions to the serious challenges that face the Medicare Program.

Statement of Len Fishman, President, American Association of Homes and Services for the Aging

The American Association of Homes and Services for the Aging (AAHSA) is pleased to present written testimony to the House Ways and Means Health Subcommittee on the revisions that must be made in the 1997 Balanced Budget Act's provisions that apply to long-term care providers. As members of Congress are realizing, deep cuts in Medicare funding for skilled nursing facilities have had unintended consequences that are severely affecting vulnerable Americans residing in our nation's skilled nursing facilities. We welcome the opportunity to provide input and comments to the Subcommittee about how we can better serve the aging population.

AAHSA is a national non-profit organization representing more than 5,300 not-for-profit nursing homes, continuing care retirement communities, assisted living

and senior housing facilities, and community service organizations. More than half of AAHSA's members are religiously sponsored and all have a mission to provide quality care to those in need. Every day AAHSA members serve one million older persons across the country.

The Balanced Budget Act of 1997 was intended to rein in the growth of Medicare expenditures on post-acute care by encouraging providers to become more efficient. However, the ways in which the new payment systems have been implemented have had unintended consequences for Medicare beneficiaries receiving care from skilled nursing facilities and home health agencies.

Skilled Nursing Facilities

In 1997, the Balanced Budget Act was expected to save $9.5 billion over five years from Medicare funding of skilled nursing facilities by changing the payment system from a cost-based reimbursement to a prospective payment system that reimburses for care based on residents' needs. This new system reduced Medicare spending on skilled nursing facilities by 17 percent. The prospective payment system for skilled nursing facilities provided payment rates for the average cost of providing care to patients based on defined Resource Utilization Groups (RUG–IIIs). The system that went into effect July 1, 1998 is being phased into national rates over four years. Under prospective payment system rates, skilled nursing facilities are reimbursed for the bundle of all Medicare Part A and Part B services provided to residents covered under a Part A stay. This forces the skilled nursing facility to act as a prudent buyer of services and to provide cost effective care. The efficiency encouraged by the prospective payment system was expected to account for the 17 percent reduction in funds.

In developing the prospective payment rates for the RUG classifications, non-therapy ancillary services such as prescription drugs, ventilator care, wound care and prosthetics represented approximately 43 percent of the nursing component. Whereas the nursing component costs were developed with staffing time measurements within the RUG–III classification system, non-therapy ancillary costs were lumped into the RUG–IIIs without regard to the type, amount, and cost of the services required and provided to patients within each grouping. HFCA has a contract for research to modify the RUG–III classification of non-therapy ancillary costs. However, the research is not expected to be completed until early 2000 for changes to be in effect by October 2000.

AAHSA does not oppose the prospective payment system, because we recognize the need to control the growth of Medicare costs. However, the RUG–III payment rates that HCFA developed do not accurately reflect some important costs involved in providing essential care to nursing facility residents. At the time the Balanced Budget Act was considered, Congress recognized that payment rates must be sufficient to meet the needs of nursing facility residents with complex conditions. The conference report on the Balanced Budget Act stated, "It is the intent of the Conferees that the Secretary develop case mix adjusters that reflect the needs of such patients," (House Report 105–217, page 758). The RUG–III payment rates that are now in effect do not meet this criterion for medically-complex residents.

As not-for-profit providers, AAHSA members are driven primarily by the goal of fulfilling their mission of providing high-quality medical care to their residents. Furthermore, nursing facilities, unlike all other health care providers, are subject to federal quality standards under the Omnibus Budget Reconciliation Act of 1987, which requires skilled nursing facilities to maintain every resident at his or her highest practicable level of functioning. This requirement limits the degree to which skilled nursing facilities can achieve efficiencies by cutting costs.

Many AAHSA members now are in a difficult position. On the one hand, their mission and legal obligation is to provide as much care as is necessary to achieve and maintain a resident's highest level of functioning. On the other hand, there is a large discrepancy between the per diem rates that Medicare pays and the actual cost of caring for medically-complex residents. While AAHSA members do not have to show a profit, there is a limit to the amount of losses that they can absorb. Although the prospective payment system has been in effect for just over a year, we are hearing increasingly from skilled nursing facilities that have had to dip into endowments or step up charitable fundraising in order to subsidize the care of Medicare residents with complex needs. These funding sources generally have been reserved for other needy residents who have exhausted their personal financial resources, and to supplement reimbursements under the Medicaid program, which also does not pay its fair share of the cost of care. Having to use charitable funds to supplement inadequate Medicare reimbursement puts a severe strain on nursing facilities' ability to serve all of their residents.

Because of the flaws in the way the RUG–III categories were designed, Medicare spending on skilled nursing care is falling below the levels that facilities can absorb by becoming more efficient. In fact, it appears that the way in which the prospective payment system has been implemented will cut the growth of Medicare spending far more than the $9.5 billion that originally was projected. Although the numbers are still being reviewed as to whether more money than expected have been removed from skilled nursing facility services, the fact remains that vulnerable residents in need of quality skilled care in nursing facilities are being hurt by the unintended consequences of the budget cuts.

In addition to lower funding than is needed to provide quality care, the distribution of funds is also inequitable. The prospective payment system's payment rates according to RUG–III are averages. Individual residents of a skilled nursing facility rarely consume the average cost of nursing, therapy and non-therapy ancillary services. Some require less, others slightly more, which averages out. However, a few residents require substantially more care and services, and thus significantly higher costs, than ever expected for the average resident. Most of the excessive costs are for non-therapy ancillary services. Examples of medically complex patients requiring extraordinarily expensive non-therapy ancillary costs include the following:

- In Michigan, a skilled nursing facility provided over $80,000 in intravenous medications to a resident with cancer who was in the facility for 27 days. Of that amount, Medicare paid less than $10,000.
- A skilled nursing facility that treats residents with AIDS provides each of them with an extensive battery of medications whose daily cost exceeds $450; whereas the Medicare payment is less than $200 per day for each resident.
- A skilled nursing facility in rural Wisconsin had to close down its ventilator care unit because Medicare reimbursement fell to half of the actual cost of providing the services. The facility could not refuse to provide the care just to Medicare patients, since that would have constituted illegal discrimination under federal law, so the facility was forced to stop providing ventilator care to anyone. This facility had been the only provider of ventilator care in a large geographic area that covered several counties and portions of three states. As a result, many patients who were ready to leave hospitals in the vicinity but who needed ventilator care had to remain in the hospital because they had no other access to the care they needed.
- After providing wound care at a cost of over $200 a day for a resident who had had an amputation, a skilled nursing facility provided him with a prosthetic device costing over $9,500 so that he could maintain the greatest degree of independence possible. Medicare reimbursed his care at less than $200 per day.
- A facility admitting a resident who needs renal dialysis 3 to 4 times a week will incur ambulance costs for each trip and will receive only $145 per day.

As indicated by these examples, the new reimbursement system imposes large shortfalls on skilled nursing facilities that serve patients needing expensive non-therapy ancillary services. Most facilities cannot absorb the large losses that the new reimbursement system imposes on an indefinite basis.

Recommendations

Restore a limited amount of Medicare funding to skilled nursing facilities: As noted above, HCFA's implementation of the Balanced Budget Act is resulting in far greater spending cuts in skilled nursing than were projected when the law originally was passed. Excessive cuts in skilled nursing facility reimbursement should be mitigated by eliminating the minus one percent reduction in the market basket adjustment of the base year for the fiscal years after 1995.

Add limited amounts of reimbursement, on a temporary basis, to the RUG III categories that represent medically-complex residents: For the most part, the reimbursement rates under the prospective payment system roughly equate to the actual cost of providing care, and modest shortfalls average out with correspondingly modest higher payments. In some RUG III categories, however, inadequate accounting for non-therapy ancillary costs has led to a severe discrepancy between reimbursement rates and the actual costs of care. These categories need a temporary adjustment for the next several months until HCFA's current research is completed and the agency is able to make a permanent revision in the rates to make a more appropriate allowance for non-therapy ancillary costs.

Based on AAHSA's analysis of SNF PPS claims, medically complex residents are classified into a variety of RUG–III categories. All the residents classified into the extensive services and special care RUG–III categories are medically complex with very high non-therapy ancillary cost per day. This is supported by a study conducted by Abt and Associates that was funded by HCFA. The Health and Human Services Office of Inspector General recently reported that hospital patients in the extensive services and special care categories had difficulty gaining placement in skilled nurs-

ing facilities. In addition, medically complex residents who receive therapy often are classified into one of the rehabilitation RUG–III categories. According to AAHSA's research, most residents in the medium and high rehabilitation RUG–IIIs have non-therapy ancillary costs per day that exceed the amount reimbursed. The RUG–III groups deserving limited add-ons to the PPS rates include: SE3, SE2, SSC, SSB, SSA, RMC, RMB, RHC, RHB, RVC, RVB, RUB.

Carve extraordinarily expensive services out of the prospective payment system: The majority of services that are extraordinarily costly, beyond the ability of a skilled nursing facility to average out under the prospective payment system, fall into three areas: infusion drugs, especially those used for chemotherapy; custom-fit, lower-limb prosthetics; and ambulance transportation for residents needing kidney dialysis. While the prospective payment system averages the cost of these services among all skilled nursing facilities, the individual facility that provides these services experiences catastrophic costs that the PPS rates based on average reimbursement cannot possibly cover. These services represent a small percentage of all skilled nursing care, but their costs are so high that they can adversely impact an individual facility or cause severe access problems to Medicare beneficiaries requiring these services.

Include the Part B add-on in the facility-specific rate for facilities in states that participated in the case-mix demonstration: Under the Balanced Budget Act, Congress attempted to establish an equitable transition period for facilities in states that took part in the Multistate Nursing Home Case-Mix and Quality Demonstration project. During the demonstration, Medicare Part A residents received ancillary services billed to Medicare Part B that should have been reflected in the facility-specific rate under PPS. However, HCFA has interpreted the law to exclude these Part B costs from the facility-specific rate. As these cost are bundled into the PPS rates, excluding the Part B add-on from the facility specific rates means reimbursements that do not cover the cost of services for facilities in the demonstration states. In evaluating the comments that it received on various aspects of the prospective payment system, HCFA noted that, "a Part B add-on to the facility-specific rate for providers participating in the NHCMQD in 1997 could well be an appropriate payment policy in light of the historical circumstances." HCFA has concluded, however, that the specific language of the BBA precludes the agency from implementing a reasonable treatment of Part B costs in the transition formula for facilities in the demonstration states. Congress must correct this inequity by including the Part-B add-on in the facility-specific rate for these nursing facilities.

Skilled nursing facilities—therapy caps

Effective January 1, 1999, the Balanced Budget Act limits Medicare beneficiaries to an annual beneficiary cap of $1,500 for physical therapy which includes speech-language pathology and a separate $1,500 cap for occupational therapy. The only exception is unlimited rehabilitation services from an hospital outpatient facility.

Beneficiaries living in the community have the option of switching from an independent therapist to a hospital outpatient facility. . Residents of a skilled nursing facility, on the other hand, may not receive therapy in any other setting or by another provider other than the skilled nursing facility. The therapy cap is a restriction based on where the Medicare beneficiary resides and receives rehabilitation services, and it therefore discriminates against residents of skilled nursing facilities.

Medicare beneficiaries in skilled nursing facilities require rehabilitative services to restore and maintain functioning that might enable a return to the community or enhanced quality of life. Residents of a skilled nursing facility are limited as to where they may receive therapy by the very nature that they required placement in a skilled nursing facility. The Part B therapy caps place unfair and unrealistic limitations on services available to these Medicare beneficiaries. Nursing home residents often have multiple co-morbidities or multiple episodes that require more therapy than the cap allows.

The therapy caps have imposed severe reimbursement shortfalls on nursing facilities that compound the problems resulting from the prospective payment system. Federal nursing home quality standards mandate that nursing facilities provide whatever therapies are medically necessary in order for residents to regain and maintain their highest practicable level of functioning. Nursing facilities therefore are forced to absorb the cost of providing medically-necessary therapy services that exceed the Medicare caps.

Recommendation

AAHSA strongly urges Congress to pass S. 472 and H.R. 1837, legislation to ease the therapy caps for Medicare beneficiaries in nursing facilities who encounter mul-

tiple episodes or who have multiple conditions requiring physical, speech, or occupational therapy.

Home Health Reimbursement

The combined effects of the Balanced Budget Act of 1997, Operation Restore Trust, and the Omnibus Reconciliation and Appropriations Act of 1998 have left Medicare-certified home health services in turmoil. Reimbursement levels were severely cut by the interim payment system; numerous federal agencies are strongly scrutinizing the industry for fraud; and adjustments made last year to the interim payment system provide little relief to home health agencies, especially those that care for the sickest beneficiaries.

The home health interim payment system that was included in the 1997 Balanced Budget Act significantly lowered the reimbursement level for home health agencies for cost reporting periods beginning on or after October 1, 1997. At the time of its passage, Congress and the Administration calculated that the interim payment system would cut $16 billion in home health expenditures over a five year time period. This past March, the Congressional Budget Office (CBO) determined that the savings will approximate $79.1 billion over five years. It therefore appears that home health savings over the 5-year period will far exceed the $16 billion target.

Reimbursement was cut so low by the interim payment system that small, rural and/or traditionally cost-efficient agencies (those already providing the fewest visits and services that were medically necessary, most often not-for-profits) are being forced out of business. Furthermore, many agencies' ability to care for sicker patients in need of complex services or multiple visits have been severely restricted. Adjustments made to the interim payment system in 1998 were too late to prevent the demise of approximately 14 percent (1,261) of the nation's home health agencies, as recently reported by the GAO (GAO/HEHS–99–120). More will fail this year without additional relief. HCFA's OSCAR data through mid-August of this year indicates that 2,486 home health agencies have closed, up from 554 agency closures in June 1998.

While AAHSA appreciates the finding of the aforementioned GAO report, Medicare Home Health Agencies: Closures Continue, With Little Evidence Beneficiary Access Is Impaired: "home health agency closures due to implementation of the interim payment system are consistent with interim payment system incentives to control utilization," AAHSA remains concerned that the data analyzed for the study does not reflect the current status of home health access. Unfortunately, this study used beneficiary utilization data from the first quarter of 1998 and compared it to similar data in 1994 and 1996. While this was the best available data at the time, we urge Congress to request further study as more reliable, up-to-date data becomes available. We also must recommend that Congress continue to hear from beneficiaries and their caregivers as to how all of these changes are affecting their access to home health services, keeping in mind that consumers may have a limited understanding of the Medicare home health benefit's eligibility and coverage guidelines.

AAHSA members surveyed earlier this spring reported various effects of the implementation of the Balanced Budget Act across the continuum of care. Our members who provide home health services are experiencing declines in admissions either because hospitals with captive home health agencies are not referring patients to other home health agencies, or due to fears associated with inappropriate referrals from doctors, an outgrowth of the intensified scrutiny from Operation Restore Trust. Moreover, AAHSA home health members report decreases in their home health reimbursements under the interim payment system ranging from 10 to 33 percent.

The home health interim payment system must be adjusted so that the medically complex, sickest beneficiaries do not lose access to care. At the same time, HCFA must work with home health providers to assure that their upcoming introduction of a home health prospective payment system is fair to all stakeholders including the beneficiaries and the federal budget. We must assure quick implementation of a new home health prospective payment system that does not penalize cost-efficient home health agencies or that creates competitive disparities among agencies.

Recommendations

While the interim payment system is in effect, Congress must amend it to assure access to beneficiaries by providing relief to home health providers. AAHSA urges Congress to:

1. Eliminate the additional 15% cut due in Oct. 2000
2. Establish an outlier for medically complex beneficiaries
3. Provide IPS overpayment relief

4. Revise per visit limits to at least 108% of the national median

While there are at least eight bills under consideration in the House addressing the home health interim payment system, AAHSA urges you to consider bills introduced which address these items including Rep. Emerson's H.R. 2744, Reps. Riley and Etheridge's H.R. 2546, Reps. McGovern, Coburn and Weygand's H.R. 1917, and Rep. Watts' H.R. 2628.

Conclusion

In the long run, the new Medicare prospective payment systems for skilled nursing facilities and home health providers will help to slow the growth of Medicare spending by making post-acute care more efficient. The ways in which these systems have initially been implemented, however, have resulted in larger spending reductions than Congress intended and in sizeable discrepancies between Medicare reimbursement rates and the actual cost of providing care. These discrepancies pose serious difficulties for not-for-profit skilled nursing facilities and home health agencies that already have been providing high quality care in an efficient manner.

Not-for-profits cannot provide services indefinitely when the reimbursement they receive falls far short of the actual cost of providing the care and results in significant financial losses to the provider. Medicare beneficiaries with complex needs already are having some difficulty in accessing care; these access problems are likely to worsen if changes are not made in the reimbursement rates. Some funding must be restored to Medicare post-acute care, and adjustments in the prospective payment rates must be made in order to ensure the continued availability of post-acute care not only to Medicare beneficiaries, but to the wider community as well.

Finally, Congress must keep in mind that when the government does not pay its share of the cost of care, beneficiaries of government programs will not be the only ones to have difficulty obtaining services or to receive inferior care. Health care providers cannot discriminate against Medicare beneficiaries in either the nature or quality of services they provide. As reimbursement rates fall too far below the costs of providing care, providers are likely to drop out of the Medicare program or discontinue certain services for any patients, no matter what kind of insurance coverage they have. Evidence of this is occurring within the home health industry. If health care providers are forced to cut corners to keep their costs at levels that will be reimbursed, these quality reductions will affect all of their patients, not just those covered by Medicare. Unless the problems that have arisen under the Balanced Budget Act are corrected, the quality and availability of health care services for all consumers, not just Medicare beneficiaries, will be affected.

Statement of American Clinical Laboratory Association

The American Clinical Laboratory Association ("ACLA") is pleased to have the opportunity to submit this statement with regard to the Subcommittee's consideration of issues related to the Health Care Financing Administration's ("HCFA") implementation of the Balanced Budget Act of 1997 ("BBA"). ACLA is an association of independent clinical laboratories located throughout the United States, whose members account for over half the laboratory services furnished by independent laboratories. All ACLA members are directly affected by certain provisions of the BBA pertaining to coverage and payment for clinical diagnostic laboratory tests. In our statement, we will review the impact of various BBA provisions on clinical laboratories, including a key provision that has yet to be implemented; discuss the current status of BBA reforms as they apply to laboratory services; and provide ACLA's view on possible action.

The BBA introduced sweeping changes to the Medicare program, representing some of the most extensive reforms since the enactment of Medicare in 1965. The BBA also recognized the importance of greater uniformity in regulations and payment policies applicable to laboratories. Policy differences among local carriers had created significant problems for laboratories, especially those that operated in more than one state. Because of these differing policies, Medicare may pay for testing in one state but not in another. In fact, two physicians practicing across the hall from one another could each order the same laboratory tests and put down the same information on the requisition; yet, one carrier would pay for the testing, while another would not. In some cases, this would result in one patient having to pay for testing that would be covered by Medicare somewhere else. Obviously, this is grossly unfair to Medicare beneficiaries.

The BBA adopted a two-part strategy to remedy this problem. First, it required HCFA to develop uniform coverage and administrative policies for laboratory tests using a negotiated rulemaking process. Second, it proposed to reduce the number of carriers processing clinical laboratory claims in order to facilitate more uniform claims processing. While HCFA has acted to implement the negotiated rulemaking provisions, it has taken no action on the regional carrier requirements.

HCFA convened the negotiated rulemaking committee required by the BBA in July 1998. This Committee, which included representatives of the laboratory and medical community and HCFA, was charged with developing uniform coverage, administration and payment policies for laboratory tests payable under Part B of the Program. The BBA required that these national policies be "designed to promote program integrity and national uniformity and simplify administrative requirements with respect to clinical laboratory tests."

In August 1999, the negotiated rulemaking committee completed work on a draft notice of proposed rulemaking. That document will include over 20 national policies covering about half the volume of clinical laboratory tests, which will help reduce the disparity in the treatment of clinical laboratory tests. The negotiated rulemaking committee's work is a major step toward the goal of increasing uniformity. ACLA applauds HCFA and the other members of the committee for their hard work in completing this process.

It will, however, be at least two years before the rulemaking is final and its policies are effective. In the interim, differences in carrier policies will continue to present inequities in the treatment of laboratories and Medicare beneficiaries. Even after the policies are effective, however, local carriers will have wide discretion in the development of payment and claims processing policies, so long as their local requirements do not conflict with national coverage policies. Disparities in how claims for laboratory testing are processed and reimbursed are, therefore, likely to continue. For example, ACLA is aware of a situation where one laboratory lost a significant contract to another laboratory because the first laboratory was in a jurisdiction where the carrier required significant documentation for all laboratory testing. The carrier for the jurisdiction where the other laboratory was located required less documentation. Because the laboratory has to obtain the documentation from the physicians ordering the tests, the physicians decided to switch to the other laboratory to avoid these more onerous documentation requirements.

It was to resolve these types of differences that Congress included the second provision in the BBA—the regional carrier provision. The provision, section 4554(a) of the BBA, requires HCFA to reduce the number of carriers processing laboratory claims from the current 34 to no more than five. One carrier in each region would be responsible for processing laboratory claims under Part B of the Medicare program. The purpose of this provision was to reduce the differences in the various rules applicable to laboratory claims. The BBA called for this provision to be in place by July 1, 1999.

Despite the statutory requirement, HCFA has failed even to initiate the process of designating regional carriers. Moreover, it has not provided any explanation or justification for the delay. In 1998, the Administration included a proposal to repeal the regional carrier provision. Congress, however, rejected the Administration's proposal to repeal the regional carrier provision. In fact, the House Appropriations Committee report specifically directed HCFA to recognize the establishment of regional carriers as a priority. Nonetheless, no action has been taken on this provision.

The administrative simplification provisions of the BBA were designed to work in tandem to achieve greater uniformity in the process of clinical laboratory testing—a goal that would ultimately redound to the benefit of laboratories, physicians and most of all beneficiaries. Such a result would reduce the costs of claims processing, increase predictability concerning what testing would be paid for, and eliminate unnecessary regulatory burdens. Congress implemented a two part strategy to achieve this aim—uniform policies through negotiated rulemaking *and* regional carriers. While HCFA has almost completed work on the first piece, it has yet to start on the second. ACLA strongly urges the Subcommittee to direct HCFA to implement the regional carrier provision.

ACLA appreciates the opportunity to comment on these issues. We would be happy to work with the Subcommittee on helping resolve any of these issues.

Statement of American College of Physicians-American Society of Internal Medicine

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing over 115,000 internal medicine physicians and medical students, appreciates the opportunity to comment on needed refinements to the Medicare provisions of the Balanced Budget Act of 1997 (P.L. 105–33). Our membership includes practicing physicians, teaching physicians, residents, students, researchers, and administrators who are directly affected by provisions of the BBA. We are particularly concerned about provisions that undermine the financial viability of our nation's teaching hospitals, imperil the educational mission of teaching hospitals, threaten the provision of care to underserved populations, and jeopardize our nation's medical research enterprise. This statement addresses three areas impacted by the BBA: cuts in Medicare payments for the indirect costs of graduate medical education (IME), refinements in calculations of physician payments for Resource-Based Practice Expenses (RBPE), and the Sustainable Growth Rate (SGR) System for Medicare Part B.

Indirect Graduate Medical Education Payment Reductions

Under the BBA, Medicare adjustments for indirect medical education expenses (IME) are scheduled to be reduced from the 1997 level of 7.7% for every 10 percent increment in a hospital's resident-to-beds ratio to 7.0% in FY 1998; 6.5% in FY 1999, 6.0% in FY 2000, and 5.5% in FY2001 and thereafter. Medicare IME payments were designed to reimburse teaching programs for the added costs of supervision, caring for indigent patients, overhead, and other costs associated with an educational environment. Teaching hospitals often serve as providers of health care for inner-city populations that otherwise are underserved. They provide substantial amounts of uncompensated care for poor and indigent patients. Graduate medical education is the linchpin for these inner-city "safety net" hospitals, and they cannot survive if their educational programs are not adequately funded.

The BBA reductions in Medicare IME payments to teaching hospitals were originally estimated to save $5.6 billion between 1998 and 2000. However, indications are that the cuts from the BBA are much greater than anticipated. The BBA was expected to reduce payments by $103 billion over five years (1998–2002). However, two years into BBA's implementation, estimates now place its impact at $191.5 billion, 86 percent more than originally anticipated. These excessive cuts will further jeopardize the survival of teaching hospitals and their programs of graduate medical education.

Cutbacks in Medicare funding and the growth of managed care in both the public and private sectors threaten the viability of many teaching hospitals. A recent study of the impact of Medicare BBA reductions by the Lewin Group indicates that hospitals will lose an average of 4.4 percent on Medicare charges by 2002. Without relief from the BBA cuts, 70 percent of all hospitals will lose money on Medicare charges by 2002. The typical teaching institution will lose $47 million in Medicare reimbursements between 1998 and 2002. Without change the scheduled BBA reductions will cut funding for the typical teaching hospital by $12.6 million in the year 2002 alone. Urban hospitals typically lost money on Medicare charges in 1999, and will lose 4.0 percent in 2002. Rural hospitals began losing money on Medicare charges as early as 1996, and without modification of BBA will lose 7.1 percent in 2002. In this increasingly competitive environment, academic health centers face decreased payment for services, decreased volumes of clinical services, and loss of market share. Meanwhile, they continue to treat the most severely ill patients and care for the poor and the indigent.

The BBA cuts also jeopardize our nation's medical research enterprise. In addition to caring for patients and educating the next generation of physicians, medical schools and teaching hospitals serve as the crucible for much of the nation's medical research. By combining research with medical education and clinical care, teaching hospitals help translate the promise of scientific discovery into better health and improved quality of life for all Americans. Medicare BBA cuts undermine the ability of teaching hospitals to perform this vital mission.

The American College of Physicians-American Society of Internal Medicine urges the Subcommittee to stop further implementation of the BBA reductions in Medicare IME adjustments. Freeze the cuts at the current level of 6.5 percent. Without such action, further implementation of the BBA will result in reductions in IME

payments of 28.57 percent over four years, reducing the IME adjustment from 7.7 percent in FY 1997 to 5.5 percent in FY 2001.

Specific legislative relief is necessary for hospitals that provide a disproportionate share of care to the indigent. The BBA provides for a 5 percent reduction in disproportionate share adjustments (DSH) over five years. Since the law was enacted two years ago, Medicare DSH payments have already been reduced by 2 percent.

Accordingly, ACP–ASIM supports "The Graduate Medical /Education Payment Restoration Act of 1999 (HR 1785/S 1023) introduced by Representative Charles Rangel (D–NY) and Senator Daniel P. Moynihan (D–NY), which would freeze the reductions in the IME adjustment at 6.5 percent. The College also supports "The Medicare Hospital Emergency Assistance Legislation (HEAL) Act (HR 2266) sponsored by Representatives Nita Lowey (D–NY) and Jack Quinn (R–NY), which would freeze Medicare DSH cuts at FY 1999 levels and stop further cuts in IME payments.

We further recommend support of other legislation that would help restore crucial funding required by the nation's teaching hospitals, including "The Hospital Outpatient Preservation Act" (HR 2241/S 1263), sponsored by Representative Mark Foley (R–FL) and Senator James Jeffords (R–VT) and "The Managed Care Fair Payment Act of 1999" (HR 1103/S 1024). HR 2241 would establish a payment floor to limit losses for hospitals that incur large payment reductions under BBA. HR 1103 provides that DSH payments for Medicare+Choice enrollees should go directly to eligible hospitals.

Implementation of Resource-Based Practice Expenses (RBPEs) to the Medicare Physician Fee Schedule

Section 4505(d)(1)(C) of the Balanced Budget Act of 1997 (BBA 97) requires the Health Care Financing Administration (HCFA) to develop a refinement process to be used during each of the four years of the transition period to full resource-based practice expenses (RBPEs). In the November 2, 1998 final rule, HCFA outlined the steps it is undertaking to resolve the outstanding general methodological issues. These steps include: the establishment of a mechanism to receive additional technical advice for dealing with these broad practice expense relative value unit (RVU) methodological issues; evaluation of any additional recommendations from the U.S. General Accounting Office, MedPAC, and the Practicing Physicians Advisory Council; and consultation with physicians' and other groups about these issues.

ACP–ASIM is pleased that the refinement process is well underway and we believe that it is progressing reasonably well considering the complexity of the issue. HCFA has awarded a contract beginning in May 1999 to obtain assistance in evaluating various aspects of its practice expense methodology. HCFA believes that the awarding of the methodological support contract and the establishment of the Practice Expense Advisory Committee (PEAC) as a subcommittee of the AMA Relative Value System Update Committee (RUC) represent important steps in its refinement process. The RUC/PEAC is a multi-specialty group, chaired by the AMA, which provides recommendations to HCFA on refinement of work and practice expense RVUs. HCFA has stated that it intends to rely on the RUC/PEAC for advice on refinement of the direct practice expense inputs during the congressionally-mandated four-year refinement period.

At a meeting last week in Seattle, the RUC/PEAC established a process and ground rules for refinement of direct practice expense inputs. This will allow the RUC/PEAC to provide HCFA with recommendations for correcting any errors in the direct practice expense inputs as RBPEs are phased in over calendar years 2001 and 2002. In the meantime, the comment period on HCFA's notice of proposed rulemaking on the calendar year 2000 physician fee schedule provides an opportunity for interested parties to make recommendations on code-level direct practice expense RVUs for calendar year 2000.

The contractor providing HCFA with technical assistance is preparing recommendations on complex issues that HCFA is likely to thoroughly evaluate before making decisions. Some of the activities that HCFA has requested that the contractor undertake are:

- Evaluation of the validity and reliability of American Medical Association (AMA) Socioeconomic Monitoring Survey (SMS) data for the specialty groups.
- Identification and evaluation of alternative and supplementary data sources from specialty and multi-specialty societies.
- The development of options for validating the Harvard and RUC physician procedure time data.
- The evaluation of the indirect cost allocation methodology.
- The development of options for the five-year review of practice expense RVUs.

Some specialties have expressed concern that HCFA intends to edit out certain clinical staff costs for services provided in a health care facility other than a physician's office. HCFA has stated, however, that it cannot pay for such services because they represent duplicate payments for services already paid under Medicare Part A; are not typical practice expenses incurred by physicians; and represent costs that are not payable under Medicare rules and payment policies. ACP–ASIM agrees that it would be inappropriate for HCFA to pay for such costs at this time, since the evidence to date does not support a conclusion that such costs are typical. However, the RUC/PEAC has agreed to consider data from specialty societies that could support the inclusion of such costs for selected services. We agree that such issues should be addressed by the RUC/PEAC refinement process.

We recognize that some are recommending that HCFA delay for one year its decision to edit out clinical staff in facility settings until the RUC/PEAC examines this issue. ACP–ASIM disagrees. A delay would mean that, in the meantime, such costs would be included in the practice expense RVUs for calendar year 2000 even though the RUC/PEAC has not had the opportunity to examine the data to support their inclusion. In our view, resource based practice expenses require that adequate data be presented, as validated by a peer group like the RUC/PEAC, to support the inclusion of certain costs in the practice expense RVUs before it is assumed that they should be included—not the other way around.

Given that calendar year 2000 transition payments will be based 50% on RBPEs and 50% on historical charges, no specialty will be subjected to extreme reductions next year as a result of requiring them to first present their data to the RUC/PEAC before a decision is made on recommending to HCFA that such costs be included in the practice expense RVUs. Since the impact of HCFA's decision to edit out the clinical staff time for facility services is less than two percent, plus or minus, for most specialties when RBPEs are fully implemented in 2002, the impact of editing out these costs will be a change in payments of only one percent for most specialties in calendar year 2000.

To summarize, ACP–ASIM believes that substantial progress has been made on refining the practice expense RVUs as mandated by the Balanced Budget Act of 1997:

- HCFA has proposed improvements in its methodology as part of its notice of proposed rulemaking on CY 2000 fee schedule payments. This notice provides an opportunity for interested parties to recommend specific corrections in code level practice expense RVUs for consideration for CY 2000 payments.
- The RUC/PEAC has agreed to a process to consider data from specialties to refine direct PE–RVUs during the transition to RBPEs. The RUC/PEAC process will allow for consideration of data on controversial issues such as HCFA's proposal to eliminate payment for clinical staff costs of services in the facility setting.
- The fact that payments in calendar year 2000 will be based 50% on RBPEs and 50% on historical charges will ease any adverse impact on physicians who may be disadvantaged during the time that the RUC/PEAC is considering data on the code-level practice expense refinements, including data on clinical staff costs in the facility setting.
- HCFA's contractor will provide recommendations for further improvement in HCFA's data and methodology.

Consequently, ACP–ASIM strongly believes that there is no need for Congress to amend the Balanced Budget Act of 1997 to mandate a further delay in the transition to RBPEs, to limit the amount of payment changes that may occur in each year of the transition, or to in other ways modify the BBA 97 provisions relating to practice expenses.

The Ways and Means Committee should also be aware that one provision of the BBA 97 relating to practice expenses is currently being adjudicated. A United States Magistrate Judge in Illinois filed a report on September 8, 1999 in favor of the federal government in a lawsuit challenging how the Health Care Financing Administration calculates resource-based practice expenses for physician services.

The lawsuit, which was filed on behalf of a group of surgical and medical specialty societies, argued that HCFA violated the law by using 1998 practice expense relative value units (RVUs) in determining Medicare practice expense payments in 1999, 2000, and 2001. ACP–ASIM and several other medical societies had filed a "friend of the court" (amicus) brief supporting HCFA's interpretation of the law.

The issue at stake in the case is whether or not HCFA was correct in using the practice expense relative value units (RVUs) that were in effect in 1998 as the base year for calculating practice expense payments during the transition to resource based practice expenses. (During the transition, practice expense payments in calendar years 1999, 2000, and 2001 are a blend of historical charges and resource based practice expenses. The percentages of resource-based PE–RVUs to be used

was 25% in 1999, 50% in 2000, 75% in 2001, and 100% for 2002). The 1998 practice expense RVUs included a "down payment" for office visits, as mandated by the Balanced Budget Act of 1997, which raised the PE–RVUs for office visits but lowered them for several hundred procedures. Specifically, the 1998 PE–RVUs for certain services were reduced to 110% of their work RVUs for the service, and the money would be reallocated to raise the PE–RVUs for office visit procedures. The amount of this reallocation was limited to $390,000,000 in 1998. The magistrate concluded that HCFA's decision to apply the 1998 "down payment" for office visits for the subsequent transition years is a reasonable interpretation of the law.

ACP–ASIM expects that a final decision on the lawsuit will be forthcoming soon. The decision hopefully will put an end to the disagreement over the meaning of the Balanced Budget Act of 1997 in regard to the "down payment" for office visits and the subsequent transition to RBPEs. We do not believe that it will be necessary for Congress to intervene in this issue at this time, given that a resolution may soon be forthcoming through the judicial process. Any effort to amend the BBA 97 provisions on the "down payment" and subsequent transition will open up Congress to a very divisive and unnecessary debate over issues that may be close to being settled in the courts.

Sustainable Growth Rate (SGR) System for Medicare Part B

ACP–ASIM urges Congress to fix Medicare's Sustainable Growth Rate (SGR) system to ensure that the 84 percent of beneficiaries enrolled in fee-for-service under Medicare continue to receive the access and benefits to which they are entitled. Enacted in BBA 97, the SGR establishes a target growth rate for Medicare spending on physician services, then annually adjusts payments up or down, depending upon whether actual spending is below or above the target.

Physicians are the only group subject to this target, despite the fact that Medicare spending on physician services has been growing more slowly than other Medicare benefits. Although BBA 97 included measures to slow projected growth in these other benefits, the Congressional Budget Office continues to forecast much higher than average annual growth rates for other services than for physician services over the next decade.

To address this disparity, the Medicare Payment Advisory Commission (MedPAC) recommended in its March 1999 Report to Congress improvements to the SGR. These improvements included:

- Correcting HCFA's projection errors and restoring the $3 billion SGR shortfall due to these errors;
- Enacting all measures necessary to curtail volatility in payment rates and avoid steep future cuts;
- Increasing the SGR to allow for physician costs due to adoption of new technology; and
- Requiring HCFA and MedPAC to provide information and data on payment updates.

ACP–ASIM has discussed the improvements described above with HCFA officials, who generally agreed with our concerns, but noted that they did not have the authority to fix the problems described above. Accordingly, ACP–ASIM asks that Congress make legislative changes to eliminate errors in the SGR system.

In its November 2, 1998 *Federal Register* notice, HCFA indicated, "We do not believe that the Congress, in enacting the SGR, contemplated such significant variances between estimates made at different points in time." In the notice, HCFA also states that, "In the long term, [conversion factor] updates could oscillate between the maximum increase and decrease adjustments. . ." This means, in essence, that conversion factor updates could alternate between periods of inflation plus 3% and inflation minus 7%. Such dramatic swings would be highly disruptive to the predictability of physician reimbursement, and will be a particular hardship when the conversion factor is set at inflation minus 7%. This inherent instability in the SGR system is a serious problem, which must be addressed by Congress before large unintended payment cuts occur.

The disparity between Medicare's rates and physicians' practice costs will only become much wider if not fixed now. This will not only make it difficult for physicians to cover the costs of advances in technology but make it harder to provide the state-of-the-art medical care Medicare beneficiaries need and deserve.

Changes Requiring Legislation

The SGR formula has several other shortcomings that will require legislative correction. First, Congress should create an add-on to the SGR formula to allow for technological changes in medicine that increase the demand for physician services.

As first envisioned by the Physician Payment Review Commission (PPRC), the idea of a target tied to GDP included a 1 to 2 percentage point add-on for changes in medical technology. Ever-improving diagnostic tools and surgical techniques have undoubtedly contributed to growth in utilization of physician services, and to the well-being of Medicare beneficiaries. Technological change in medicine shows no sign of abating, and the SGR should include a technology add-on to assure Medicare beneficiaries' continued access to mainstream medical care.

Second, Congress should create an add-on to the SGR formula to account for the rising cost of ambulatory care practice with the shift in care from hospital inpatient settings to outpatient sites. As MedPAC has pointed out, hospitals have reduced the cost of inpatient care by reducing length of stay and scaling back on staff. Some inpatient staff and service reductions are offset by increased costs and services in physician offices and other outpatient sites.

Third, Congress should instruct the administration to periodically adjust the SGR to allow for changes over time in the characteristics of patients enrolling in Medicare+Choice plans compared to those remaining in the fee-for-service program. HCFA has stated that Medicare beneficiaries who enroll in managed care plans may be healtheir than those who stay in the fee-for-service program. If the trend is for people who are older and/or sicker to remain in the fee-for-service program, there should be an adjustment to the SGR to account for such differences in the beneficiary population. Absent such corrections, if fee-for-service payments are slashed relative to Medicare+Choice payments, the Medicare fee-for-service program may effectively dissolve, leaving beneficiaries without a viable alternative to managed care.

Fourth, Congress should raise the lower limit on SGR updates to provide a more acceptable floor on payment updates. Assuming a Medicare Economic Index of 2%, the lower limit of inflation minus 7% would imply a 5% actual cut in the conversion factor in a single year. The Medicare update formulae for other (non-physician) providers does not expose them to the degree of payment reductions that physicians are likely to experience under the SGR. Medicare+Choice payments are guaranteed annual increases of 2%. For the hospital update for a year to be analogous to the lowest potential physician update, it would have to be set at market basket minus 7%—an unlikely scenario at best.

Fifth, Congress should eliminate SGR projection errors by either giving the administration the authority to change projections as new Gross Domestic Product (GDP) data becomes available or by requiring the administration to update the SGR using actual GDP data.

Conclusions

Indirect Graduate Medical Education payment reductions

ACP–ASIM believes that Congress should:

1. Stop further implementation of the BBA reductions in Medicare IME adjustments, and freeze the cuts at the current level of 6.5 percent.
2. Limit reductions in disproportionate share adjustments (DSH) to the 2 percent already implemented by 1999 and prevent further cuts.
3. Redirect DSH payments for Medicare+Choice enrollees from managed care plans directly to eligible hospitals.
4. Establish a payment floor to limit losses for hospitals that incur large payment reductions under BBA.

Resource-Based Practice Expense (RBPE) Relative Value Units (RVU)/Refinement Process of the Medicare Physician Fee Schedule

ACP–ASIM believes that:

1. The RBPE refinement process is well underway and is progressing reasonably well considering the complexity of the issue. The administration has the authority and capability to continue the refinement process and that there is no need for Congress to change the rules or delay implementation.
2. The refinement process established by HCFA is reasonable and consistent with the provisions of the Balanced Budget Act of 1997.
3. The administration should exclude all clinical staff time allotted to the use of clinical staff in the facility setting from the raw Clinical Practice Expense Expert Panel data. However, HCFA should consider future recommendations that may be forthcoming from the American Medical Association Relative Value System Update Committee/Practice Expense Advisory Committee during the refinement process that:

- Show that it is a typical practice to employ clinical staff for the procedure codes in question and

• Document what types of services the clinical staff are providing. Any recommendations for inclusion of clinical staff in the facility setting must differentiate between physician-substitutive services (which should be addressed through the work relative value units, not the practice expense relative value units), general administrative costs (an indirect cost) or specialized clinical assistance that may represent a legitimate practice expense that should be paid by Medicare.

4. The administration should not delay for one year its decision to edit out clinical staff time in the facility setting. A delay would be contrary to the idea of a resource-based system, as it would require HCFA to continue paying for costs that have not been validated through the refinement process.

Sustainable Growth Rate (SGR) Formula

To improve the Sustainable Growth Rate Formula, Congress should:

1. Create an add-on to the SGR formula to allow for technological changes in medicine that increase the demand for physician services.

2. Create an add-on to the SGR formula to account for the rising cost of ambulatory care practice with the shift in care from hospital inpatient settings to outpatient sites.

3. Instruct the administration to periodically adjust the SGR to allow for changes over time in the characteristics of patients enrolling in Medicare+Choice plans compared to those remaining in the fee-for-service program.

4. Raise the lower limit on SGR updates to provide a more acceptable floor on payment updates.

5. Eliminate SGR projection errors by either giving the administration the authority to change projections as new Gross Domestic Product (GDP) data becomes available or by requiring the administration to update the SGR using actual GDP data.

ACP–ASIM appreciates the attention that the Subcommittee is giving to refining and correcting Medicare provisions included in the BBA and the opportunity to submit testimony. We are prepared to work with the Congress and the Administration to enact legislation that will help maintain the fiscal solvency of the Medicare program without drastically curtailing services to Medicare beneficiaries, jeopardizing our nation's medical education and research capability, or further undermining the viability of our teaching hospitals and academic medical centers.

Statement of American Medical Group Association, Alexandria, VA

The American Medical Group Association appreciates the opportunity to present written testimony for the record to the House Ways and Means Health Subcommittee on refinements that we believe need to be made to the Balanced Budget Act of 1997. The AMGA commends Chairman Bill Thomas and the Committee for holding a hearing on this important subject and appreciates your efforts to remedy the unintended consequences caused by the BBA.

The American Medical Group Association represents approximately 45,000 physicians in more than 250 medical groups from across 40 states. AMGA members are among the largest and most prestigious medical groups in the country and include such renowned organizations as the Mayo Foundation, the Palo Alto Medical Foundation, the Lahey Clinic, the Henry Ford Health System, the Cleveland Clinic, and the Permanente Federation, Inc. AMGA's mission is to shape the health care environment by advancing high quality, cost-effective, patient-centered and physician-directed health care.

The Balanced Budget Act of 1997 (BBA 97) was the most significant reform of the Medicare program since its inception in 1965. The BBA 97 encompasses over 300 changes that have had, and continue to have, significant implications and consequences for medical groups and the patients we serve. Multi-specialty medical groups are unique in that they are comprehensively involved in all aspects of health care delivery affected by the Balanced Budget Act: physician services, inpatient and outpatient hospital care, Medicare+Choice health plans, skilled nursing facilities, teaching hospitals, and home health care. Consequently, multi-specialty groups have sustained, and continue to sustain, dramatic revenue reductions which interfere with capital budgeting and patient care.

AMGA understands the need to eliminate unnecessary and wasteful services and inefficiencies. However, the reimbursement reductions imposed in BBA 97 are having a significant negative impact on the ability of medical group practices to continue to deliver quality care to beneficiaries and are threatening the financial viability of many groups. AMGA members are struggling to make up for the shortfalls caused by the BBA 97, yet, rather than compromise the quality of services they pro-

vide, groups are finding it necessary to cut back on beneficial services and uncompensated care. For your review, we have attached a few real examples of the estimated net revenue impact of specific items in the BBA 97.

Medical groups need both administrative and legislative remedies if they are going to continue delivering quality care. Relief from the Balanced Budget Act should include:

- Relief from reductions for teaching hospitals and academic medical centers. BBA 97 limits payments for IME, interfering with teaching hospitals' ability to provide quality care to the poorest and sickest individuals. Under the BBA 97, Medicare adjustments for IME are scheduled to be reduced from the 1997 level of 7.7% to 5.5% in FY 2001. These excessive cuts will further jeopardize the financial viability of teaching hospitals to provide patient care to under-served populations and conduct medical research. AMGA supports legislation introduced by Rep. Charles Rangel (H.R. 1785) and Senators Moynihan and Kerrey (S. 1023) that would freeze IME payments at current levels and prevent future scheduled BBA 97 cuts.
- Repeal the patient transfer provision. Under the expanded transfer definition, the government pays less for shorter stay payments but does not increase payment for longer-stay patients. Payments for cases shorter than average stays help defray the costs of caring for patients with longer-than-average stays. AMGA supports legislation proposed by Senator Grassley (S. 37) and Rep. Jim Nussle (H.R. 405) which would repeal this provision.
- Fix the way Medicare pays Medicare+Choice plans by:
- Requiring HCFA to implement the risk adjustment process on a budget neutral basis. The "risk adjustment" process was intended to distribute funds based on the health status of M+C enrollees, however, HCFA has proposed a model that would impose deep spending cuts in the M+C program. AMGA supports H.R. 2419, the "Medicare+Choice Risk Adjustment Amendments of 1999," introduced by Congressman Michael Bilirakis.
- Speed up implementation of the risk adjustment mechanism, permitted that it uses a reliable database that takes into account the beneficiary' heath status and medical costs. Many of our medical groups care for a disproportionate number of the sicker Medicare population and have faced a sharp reduction in Medicare payments.
- Require HCFA to modify the Sustainable Growth Rate (SGR) expenditure target. Currently, there are significant flaws in the formula that is used to calculate the annual payment update for physician services. Absent significant modifications in the SGR, physicians face payment constraints that are far more severe than Congress intended.
- Delay implementation of the prospective payment system for outpatient departments so that HCFA can address and amend the proposed rule. The proposed rule has numerous problems and would severely impact medical groups across the country. As proposed, the rule does not recognize that integrated systems have moved many services to ambulatory sites, imposes a volume cap on payment updates if Medicare payments exceed HCFA projections, and uses a methodologies that do not accurately recognize the costs of technology and treatments. We support legislation introduced by Senator Jeffords (S. 1263) and Rep. Mark Foley (H.R. 2441) that would provide for a transition period and limit payments reductions over three years.
- Restore the budget neutrality on the new prospective payment system's reimbursement methodology. The 5.7% across the board reduction in payment to outpatient departments imposes an $900 million per year reduction in payment to hospitals that was not intended by Congress in the BBA. Congress intended that payments to hospitals should remain budget neutral under the new PPS system. We support the steps taken by Reps. Johnson and Cardin, and Senators Cochran, Kerry, and Rockefeller urging HCFA to restore the budget neutrality.

Physician Self Referral Amendments

As you continue your examination of the BBA 97 in order to evaluate whether or not legislative changes are necessary, the AMGA would urge you to include language that would clarify the physician self-referral law (otherwise known as the Stark law) and bring it more in line with Congress' original intent. AMGA supports fully the intent behind the self-referral law—to prevent physicians from ordering unnecessary services in order to profit from the Medicare and Medicaid laws. However, the self-referral law has gone far beyond the original intent and it now interferes with the delivery of efficient, quality health care. The law's provisions are so vague and open to misinterpretation that is virtually impossible to conclusively determine whether certain ancillary service arrangement are or are not in violation

of the self-referral law. In addition, the "compensation arrangement" provision of the law precludes many business activities which are essential to the successful operation of multi-faceted, integrated health care organizations.

Section 4314 of the Balanced Budget Act of 1997 requires that the Secretary of Health and Human Services issue written advisory opinions to outside parties concerning whether the referral of a Medicare patient by a physician for a certain designated service is prohibited under the physician self-referral law. While Congress' intent was to help physicians better understand the law, advisory opinions have not had the desired overall effect. Instead, AMGA believes that legislative changes to the law are necessary to correct the unintended consequences of the self-referral law. AMGA supports the H.R. 2651, legislation introduced by Congressman Bill Thomas. This legislation would remove the barriers to integration and innovation, while still maintaining the original intent of the law.

Medicare Reform

AMGA commends President Clinton for taking steps to introduce a Medicare reform proposal that seeks to modernize the program, introduce private sector innovations, and help seniors pay for prescription drugs. In particular, we strongly support the creation of a demonstration project of bonus payments for physician group practices who reduce excessive use of services and demonstrate positive medical outcomes for their patients. Based on our members' experience, medical group practices are leading the way to cost-effective, high quality health care through integrated financing and delivery of medical services. A shared commitment and an underlying patient care mission by all involved have produced superior results in quality health care service and satisfaction for both patients and providers. Through organized delivery systems, providers save time, money, and resources, and improve patient care.

At the same time, we are disappointed that the President's proposal continues the pattern of cutting payments to providers as a way to maintain Medicare solvency. President Clinton's Medicare reform would cost hospitals and health plans $70 billion over 10 years. The potential for additional Medicare cuts to medical groups will be disastrous because, as integrated practices, they carry the burden of the full scope of reductions.

While we recognize the need to eliminate inefficiencies and wasteful services, the Federal government cannot finance and expand the Medicare system by cutting provider reimbursements. The President's proposed reductions come on the heels of Medicare spending reductions contained in the BBA 97, and will reduce our ability to provide quality services that the elderly depend on. While the President's establishment of a $7.5 billion provider set-aside fund appears to recognize that the BBA 97 reductions were too harsh, this funding level is insufficient to address reimbursement inadequacies and does little to ensure that Medicare beneficiaries will continue to have stable access to health care providers. More importantly, the $7.5 billion would result in battles among the provider community to determine who is most worthy of relief.

Rather than implement further reductions at the expense of health care delivery, Congress needs to do two things: First, Congress needs to fix the unintended consequences of the BBA 97. This will ensure that Medicare beneficiaries will continue to receive quality and cost-effective care from providers and medical groups. Second, if solvency of the Medicare program is to be sustained, Congress needs to fundamentally restructure and modernize the Medicare program. Such a system should be based on the principles of patient choice, competition among providers in price, marketplace innovation, a defined role for the government, and should adopt marketplace innovations. We believe that Medicare restructuring should incorporate the innovative and cost-reducing delivery system reforms that have emerged in the private sector. Continuing to reduce provider reimbursements as a part of reform is not a viable option.

The AMGA understands the budget constraints Congress is working with and has worked hard to put forward solutions that are realistic and reasonable. However, without some relief, medical groups will find it increasingly difficult to provide access to quality care to Medicare beneficiaries. It is crucial that Congress acts now to make the necessary adjustment to the Balanced Budget Act of 1997 so that medical groups can continue to provide Medicare beneficiaries the health care services they deserve and depend on. We look forward to working with the Committee on this very important issue.

Mayo Foundation—Rochester, Jacksonville, and Scottsdale

BBA Reductions (in millions of dollars)	1998	1999	2000	2001	2002	2003	Total
Reduction to IME payment Rate	6.4	13.9	20.5	26.5	28.5	30.7	120.1
PPS-exempt unit TEFRA rates	–	1.0	1.0	0.9	0.8	0.7	4.3
Reduction to Federal capital payments	5.1	5.6	6.0	6.5	6.7	6.8	31.7
Transfer DRGs	0.6	2.5	2.5	2.5	2.5	2.5	12.6
Outpatient PPS (assume 5% reduction)	0.3	0.7	0.7	0.7	0.7	0.7	3.5
Outpatient formula-driven overpayments	1.1	1.7	1.8	1.9	2.0	2.1	9.4
Eliminate IME payment on outliers	3.4	3.8	3.6	3.6	3.8	4.1	19.0
SNF prospective payment	–	3.0	6.0	9.0	12.0	12.0	42.0
Reduction to bad debts	–	0.1	0.1	0.1	0.1	0.1	0.4
HHA reduction to limits and PPS0.5	0.5	0.5	0.5	0.5	0.5	0.5	2.5
Medicare Part B physician fee schedule	–	3.0	6.0	9.0	12.0	12.0	42.0
Total Reductions	18.3	35.6	45.5	54.9	60.4	63.0	259.3

Henry Ford Health System—Detroit, MI

BBA Reductions (in millions of dollars)	1998	1999	2000	2001	2002	Total
PPS-Hospital Payment Update	5.2	8.9	12.5	14.7	17.0	58.3
IME Adjustments	3.2	5.7	8.2	10.7	10.7	38.5
Capital Payment for PPS Hospitals	3.3	3.3	3.3	3.3	3.3	16.5
Transfer DRG Provision	–	3.1	3.1	3.1	3.1	12.4
Disproportionate Share Payments	0.1	0.2	0.2	0.3	0.4	1.2
Bad Debt Payments	0.5	0.8	0.9	0.9	0.9	4.0
Formula Driver Overpayments	2.9	2.9	2.9	2.9	2.9	14.5
Outpatient PPS	–	–	4.8	9.6	9.6	24.0
Physicians Single Conversion Factor	1.0	1.0	1.0	1.0	1.0	5.0
Physician Practice Expense RVUs	–	0.6	1.0	1.4	1.8	4.8
Home Health Interim Payment System	1.0	–	–	–	–	1.0
Sustainable Growth	–	1.2	1.7	1.2	1.2	5.3
HMO 2% Cap	2.2	4.6	TBD	TBD	TBD	6.8+
Risk Adjusting Scheme	N/A	N/A	TBD	TBD	TBD	TBD
User Fees	$525,000	620,000	651,000	684,000	718,000	3.2
Total Reductions	19.9	32.9	39.3	49.8	52.6	195.5+

Lahey Clinic—Burlington, MA

BBA Reductions (in millions of dollars)	1998	1999	2000	2001	2002	Total
PPS Hospital Updates	1,295,081	2,466,203	3,379,178	3,964,511	4,578,043	15,683,016
Formula Driven Overpayment	850,000	850,000	850,000	850,000	850,000	4,250,000
IME	1,322,000	2,555,000	3,266,000	4,199,000	4,199,000	15,241,000
IME Managed Care	562,500	1,500,000	2,200,000	2,900,000	3,480,000	10,642,500
Transfer Policy	–	1,000,000	1,000,000	1,000,000	1,000,000	4,000,000
APC	–	–	1,000,000	2,000,000	2,000,000	5,000,000
Single Conversion Factor	750,000	1,000,000	1,000,000	1,000,000	1,000,000	4,750,000
Resource-Based Practice Expense RVU	–	300,000	700,000	1,100,000	1,500,000	3,600,000
Total Reductions	3,654,581	6,371,203	8,995,178	11,213,511	11,647,043	41,881,516

Statement of American Medical Rehabilitation Providers Association

The American Medical Rehabilitation Providers Association (AMRPA) is pleased to submit testimony today on the Balanced Budget Act's (BBA) requirements relating to the development of a prospective payment system (PPS) for rehabilitation providers. AMRPA is a membership organization representing 360 freestanding rehabilitation hospitals and rehabilitation units. This is about 33% of such facilities recognized by the Medicare program.

I. Background

Rehabilitation hospitals and units provide medical care and various therapies to patients who, because of disease, injury, stroke or similar incidents, have impairments of their abilities to function, either physically or cognitively. Our goal is to help them regain the maximum level of functional capability and return them to their homes and independent living patterns. More than 80% of patients admitted to rehabilitation hospitals and units return to their homes, in spite of the fact that many have experienced severe disabilities. Because many of the conditions producing the need for rehabilitation are associated with aging, a significantly high percentage of patients in rehabilitation hospitals and units are covered by the Medicare program. In 1997, over 70% of admissions to such facilities were patients covered by fee-for-service Medicare. Accordingly, the policies of the Medicare program largely determine the availability and quality of rehabilitation services. And there is little room for error.

Prior to enactment of the BBA, rehabilitation hospitals and rehabilitation units in general hospitals were paid on a cost-based system (TEFRA) and were exempt from the PPS system that was designed for acute care hospitals. The TEFRA cost-based system distorted payments and services by discouraging treatment of complex patients and by creating an uneven playing field among providers.

Our association and its predecessor strongly supported the idea of a rehabilitation prospective payment system (RPPS) to replace the flawed and inequitable system of TEFRA limits which have distorted care for Medicare beneficiaries for over 15 years. We were very pleased when an RPPS was included in the BBA of 1997.

A rehab PPS can correct the mistakes created by the TEFRA system and better target Medicare funds to serve patients' needs. The Balanced Budget Act of 1997 (BBA) required the Health Care Financing Administration (HCFA) to develop a PPS for rehabilitation hospitals, and units referred to as rehabilitation facilities in the law. The BBA is completely adequate to support a rational, patient-oriented PPS. However, we believe that amendment of the law is needed to ensure adoption of a rehabilitation PPS without negative consequences, particularly for Medicare patients.

The BBA requires that the Secretary set rates in the rehabilitation PPS to reduce total expenditures for inpatient rehabilitation services by 2% from what they would have been in the absence of a PPS. Any such calculation is subject to misjudgments about volume of services, but a per-episode payment system is much more predictable than a per-diem system. The former is subject to changes in total patient volume. The latter is subject to this factor, as well as the average number of days of care which can result in increased expenditures.

II. The PPS System Recommended by MEDPAC is Completely Sound and Should be Used for an RPPS

The rehab PPS was addressed in depth in the March 1, 1999, report on the Medicare program submitted to Congress and the Administration by the Medicare Payment Advisory Commission (MedPAC). We support MedPAC's recommendations regarding a PPS for rehabilitation and related matters which parallel our views.

In its report to Congress, MedPAC recommended that the Secretary of Health and Human Services develop a rehab PPS using a per-discharge approach and a patient classification system known as the Functional Independence Measure-Function Related Groups (FIM–FRG), a payment system designed for HCFA by the RAND Corporation. The FIM–FRG is based on a patient classification system developed by researchers at the University of Pennsylvania. In its work for HCFA, RAND evaluated this classification system and designed a PPS based on it. The result is a well-developed system based on data from a large number of rehabilitation hospitals and units. We believe it accurately measures patients' needs for treatment and will fairly match Medicare payments to relative needs for rehabilitation services.

The system designed by RAND parallels the structure of the PPS used for general hospital care. Payment would be per-discharge and case-mix groups would be determined by a combination of diagnosis, age, and functional ability of the patient. These factors are the basis for the patient classification system know as FRGs.

The system designed by RAND is a per-episode system. Originally designed using data from 37,000 rehab patients in 1990 and 1991, FRGs were further refined by Rand, in 1994, with data from over 90,000 Medicare patients. As such, the system well-represents a broad range of rehab patients. HCFA and RAND now have comparable data from 1997 for over 200,000 patients and will soon have similar data for 1998. Further, patient classification and weights under the FRG system can be easily updated before the implementation date of October 1, 2000. Such data is available annually, permitting regular review of payment classifications and weights.

The FIM–FRG is a discharge-based classification system which sorts patients into 21 diagnostic categories, known as Rehabilitation Impairment Categories (RICs). MedPAC believes that a system based on FIM–FRG would be more reliable, because FIM–FRG is stable over time and predictive of length of stay and per-discharge resource use. It also contains the most complete compilation of data on rehab patients. With minor modifications, the FIM–FRG is ready to be implemented.

Adoption of the FRG system also would allow assessment of the impact of the PPS on patient care, outcomes, and quality. Existing data on outcomes—the functional improvement of patients—go back a decade or more. These data can be used to examine patient outcomes before and after introduction of a PPS. In fact, the payment system could even reward the achievement of superior results for patients.

III. Concerns About Alternative Approach

AMRPA supports HCFA's implementation of MedPAC's recommendations. However, the Department's approach may not be fully clear until it publishes its methodology, which is not expected until December 1999.

HCFA was previously developing a system similar to the PPS that was recently implemented for SNFs. The SNF PPS uses a classification system that relies on the MDS patient assessment tool designed for use in nursing facilities. HCFA was also inclined to create the rehab PPS using the analytic system known as Resource Utilization Groups (RUGS) combined with a per diem approach. However, because of the MedPAC recommendations, guidance from Members of Congress, and internal Departmental disagreements, HCFA recently announced it will follow the MedPAC recommendations. We strongly support this approach.

IV. Why AMRPA Supports per Discharge With FIM–FRG

One of the great defects of the TEFRA system is that the system strongly encouraged providers to treat patients with lesser medical complications and functional impairments and imposed a financial penalty for taking more disabled and medically complex patients. A primary goal of a PPS should be to match payment rates with varying treatment requirements so there is no financial incentive to treat one type of patient over another.

The BBA requires that a PPS be developed with rates that will result in a 2% reduction in outlays from what would have been spent in the absence of a PPS. Based on FY 1996 data, it appears that this provision of the BBA will produce a budget for rehab PPS of about $4.4 billion. The issue is how to most effectively use this amount of money to obtain the best possible rehab services for the approximately 325,000 Medicare patients admitted to rehabilitation hospitals and units each year.

Rehabilitation providers have operated under a construct that, in effect, reflects the per-episode payment system—namely, TEFRA limits—for 16 years. Such limits have encouraged reductions in lengths of stay. Average Medicare length-of-stay in rehabilitation hospitals and units has declined from about 22.6 days in 1988 to just over 16 days in 1997. A per-diem system would provide a huge incentive to reverse this trend. Based on 1997 data, a one-day increase in the average Medicare length of stay would, under a per-diem system, result in increased Medicare spending of about $240 million.

Rehabilitation is a process, and the determination as to when a patient is ready for discharge involves a number of variables, including the patient's physical and cognitive progress, his or her medical condition, the level of support in the home and the patient's attitude. These and other social and clinical factors are weighed by the attending physician and other members of a rehabilitation team in determining when discharge is appropriate. For over 15 years, Medicare has encouraged shorter lengths of stay through the TEFRA system.

Rehabilitation facilities exist to meet the needs of their patients. A payment system that discriminates against certain types of patients poses a serious problem to ethical people in the business of providing quality services and outcomes. Financial reality means that they can not treat large numbers of patients for whom the payment is inadequate. Matching services to an inadequate daily payment and keeping patients longer is a poor substitute for providing the optimum level of services and the earliest possible discharge. Providers want to be able to deliver the care that is in keeping with maximum progress for patients, and they do not want to operate under a system which chronically frustrates achieving that goal. For all the above reasons, AMRPA supports the MedPAC recommendation for a discharge based rehabilitation prospective payment system, based on FIM–FRG, and HCFA's announcement in July to pursue the FIM–FRG approach.

V. What Needs to be Done to Implement the FIM–FRG RPPS

As mentioned earlier, FRGs are currently based on 1994 data from over 90,000 patients. There are now data to support the creation of revised FRGs based on 1996 and 1997 data from over 200,000 patients. AMRPA supports updating the FRGs to a more recent year. To account for practice pattern evolution and patient mix, the FRGs could be recalculated every year, which would be a relatively easy exercise.

Since the system is currently based on 1994 data, the system's accuracy could be improved by updating either a portion or the entire system to reflect 1997, or preferably 1998 data which will soon be available. RAND is using the 1997 data which is currently available. We envision the following steps:

1. The FRGs are based on data which are currently collected voluntarily from about 80% of rehab providers. The financial data is collected by HCFA; the clinical data is gathered by UDSmr and Caredata.com (Medirisk). No site visits to hospitals are required.
2. RAND matches the clinical and financial databases on a patient-by-patient basis using sex, birth date, and admit date.
3. The charge data collected off bills by HCFA is converted to cost through multiplication of the charge by the cost: charge ratios contained on the Medicare cost reports. This is done on a per cost center basis.
4. New FRG algorithms could be calculated from the newer data. The FRG algorithms are the definitions by diagnosis, age and FIM scores which determine the break points between FRGs.
5. Rand/HCFA would then account for the distribution of cases. This is fairly straightforward since a database of 66% (220,000 cases) of the patient population is assigned to the various FRGs.
6. A high cost outlier should be developed to preserve access for unusually costly patients.

At some point, the FRGs will have to be moved to be supported by MDS–PAC data. The Minimum Data Set for Post Acute Care (MDS–PAC) is a data tool HCFA is developing to use in several sites of care. It will be critical that the same score on an MDS–PAC functional motor item can be translated to the similar FIM item, or if there is a difference, that it is accounted for in the algorithms. To ensure that it is done correctly, we recommend that RAND conduct an empirical study of the use of the FIM and MDS–PAC. It should include data being collected on the same patients using the FIM and the MDS–PAC, then analyzed with respect to FRGs to assure the MDS-PAC collects the data necessary to categorize patients into the FRGs. RAND should independently validate HCFA's work as RAND was not involved in the developmental work on the MDS–PAC.

VI. Conclusion

AMRPA believes the future of rehabilitation access is at stake in the design and implementation of the rehab PPS. We, like MedPAC, think the means are at hand to produce a sound, stable system which will provide open access and high quality service to all types of patients. However, we urge the Committee to take limited legislative action.

To direct that HCFA adopt the RAND system as the basis for a rehabilitation PPS would require only two changes in the language of the BBA pertinent to this matter. First, the payment unit for a rehab PPS should be a discharge. Second, the factors used by the RAND patient classification system—impairment, age, co-morbidities, and functional capabilities of the patient—should be made mandatory and referenced explicitly.

HCFA currently has the discretion to develop the PPS in whatever manner it prefers. This is the agency's opportunity to get the system right and avoid additional unintended consequences. We want to ensure that payment is as appropriate and

accurate for each patient as possible so more complex patients continue to have access to the services they need.

Therefore, we recommend the Committee amend the BBA to direct the Secretary of Health and Human Services to develop a rehab PPS based on a per-discharge payment unit utilizing the function related groups and the other adjustments MedPAC recommends. We thank the Committee for this opportunity to submit testimony. AMRPA looks forward to the future and our ongoing positive relationships with Congress and the Department.

Statement of American Nurses Association

The American Nurses Association (ANA) is pleased to submit this statement to the Committee on Ways and Means, Subcommittee on Health for the record of the October 1, 1999, hearing regarding refinements to the Medicare provisions included in the Balanced Budget Act of 1997 (BBA 97).

ANA is the only full-service professional organization representing the nation's 2.6 million Registered Nurses through its 53 constituent associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

ANA believes that there are many instances in which the BBA 97 made cuts to Medicare programs that were too severe and have resulted in a reduction of quality of health care and a reduction in access to health care. It has also resulted in financial hardship to many who have dedicated their lives to caring for our nation's elderly and disabled. ANA calls on Congress and the Administration to take immediate action to remedy this situation.

The legislation that most comprehensively addresses the multitude of problems caused by the BBA 97 is S. 1678, the "Medicare Beneficiary Access to Care Act." Although this is a Senate bill and not before this panel, ANA calls on this subcommittee to enact legislation similar to S. 1678.

ANA believes that the underlying problem was a mind set that allowed arbitrary budgetary targets to override genuine health care considerations. In 1997, Congress established a goal of how much it wanted to cut from Medicare. Meeting these cuts was the overriding goal. Health care consequences were secondary. As it turned out, the cuts in the BBA 97 were more severe than anticipated. Some estimates project that the BBA 97 has, in actuality, cut as much as twice as much as anticipated.

Nurses all across the nation are seeing the consequences of these cuts in both acute care settings and post-acute care settings. Some of the chief areas of concern are outlined below.

HOME HEALTH CARE

The Interim Payment System (IPS) implemented by the BBA 97 has caused severe problems for home health providers and the patients they serve. Among the impacts of the IPS for home health care are: approximately 550,000 fewer Medicare beneficiaries receiving home health services in 1998 than in 1996; the closing of nearly 25 percent of all home health agencies in the United States; and average home health agency reimbursement decreasing 29 percent since 1996.

ANA calls on Congress to take action to:

- Eliminate the 15 percent cut scheduled for October 1, 2000;
- Provide resources for an outlier provision for high-cost patients;
- Increase the IPS per-visit cost; and provide relief from financially disabling overpayments; and
- Eliminate the 15-minute billing requirement.

We believe these steps are the minimum necessary to ensure that the Medicare population has access to quality home health services.

SKILLED NURSING FACILITIES

The implementation of a prospective payment system (PPS) for skilled nursing facilities (SNFs) has resulted in greater reductions in payments than originally intended. While we do not argue that the SNF PPS needs to be eliminated altogether, we believe that it needs to be modified.

The BBA 97 intended to reduce Medicare SNF payments from $248 billion to $232 billion. It has been estimated by the Congressional Budget Office, however, that the reductions will be to $210 billion—a $22 billion shortfall.

ANA calls on Congress to:

- Create payment add-ons for certain RUG categories; and
- Update the current SNF market basket; and allow providers to transition to the federal rate effective October 1, 1999.

We believe action is necessary to reduce the burden being felt by some of Medicare's most vulnerable patients.

Acute Care

The BBA 97 has had severe impacts on many hospitals. This has resulted in a decrease in both quality of care and access to care. In acute care, as in other areas, we see that the impact of the BBA 97 cuts has been more severe than originally anticipated. While the BBA 97 intended to cut hospital payments by $53 billion over five years, the actual cuts are $71 billion—an $18 billion shortfall.

ANA calls on Congress to:

- Pass legislation that would limit payment losses created by the move to outpatient PPS;
- Adopt MedPAC's recommendation for a modest PPS update to compensate hospitals for Y2K readiness activities;
- Provide relief for rural health care providers—particularly sole community providers, critical access hospitals, and Medicare-dependant hospitals;
- Provide relief for hospitals serving the uninsured by carving out disproportionate share payments from Medicare managed care payments; and
- Fully fund Medicare managed care payment blend to provide fair payment in all parts of the country.

ANA believes this action is necessary to provide access to quality acute care for the elderly and disabled.

Conclusion

ANA believes that Congress and the Administration need to take immediate action to reduce the harm done by BBA 97 by enacting S. 1678 or similar legislation. We believe that future decisions about health care need to be made with the focus on health care needs rather than on arbitrary budgetary goals. We look forward to continuing to work with Congress and the Administration, as well as our colleagues in the health care community, as our nation deals with these issues.

Statement of American Osteopathic Association

The American Osteopathic Association, which represents 43,500 physicians, appreciates the opportunity to provide testimony on refinements to the Medicare provisions of the Balanced Budget Act of 1997.

This testimony addresses areas affected by the BBA: Graduate Medical Education; the Sustainable Growth Rate and refinement of the Resource-Based Practice Expense Relative Value Units.

Graduate Medical Education: Osteopathic medicine is separate and distinct from allopathic medicine. Consequently, osteopathic residency programs are not interchangeable with allopathic training programs. The Balanced Budget Act of 1997 and its attempts to constrain residency training programs have a much more significant impact on osteopathic medicine than on allopathic. A recent increase in the number of osteopathic students, combined with the BBA 97 provisions, means many of these students will be unable to train in osteopathic residency programs. [Attachments are being retained in the Committee files.]

Osteopathic medicine has a long tradition of serving the under-served, of providing care in rural areas. If osteopathic residents are not able to train in osteopathic programs, the tradition of serving the under-served may be threatened. Although not its intent, BBA 97 has severely impaired the expansion of residency programs in rural and under-served areas. Relief wouldbe appreciated.

The AOA endorses the "Graduate Medical Education Technical Corrections Act of 1999" (S.541/H.R. 1222) which was introduced by Sens. Susan Collins (R–ME) and Frank Murkowski (R–AK) in the Senate, and by Rep. John Baldacci (D–ME) in the House. This bill would rectify the unintended problems created by BBA 97 in regards to GME.

The AOA also endorses two separate pieces of legislation which create all-payer GME trust funds: All-Payer Graduate Medical Education Act (H.R. 1224) introduced by Rep. Ben Cardin (D–MD); and Medical Education Trust Fund Act of 1999 (S–210) introduced by Sen. Daniel Patrick Moynihan (D–NY).

The BBA reductions to Medicare adjustments in Indirect Graduate Medical Education to teaching hospitals were originally estimated to save $5.6 billion between 1998 and 2000. However, it is the AOA's understanding that the cuts from the BBA are much greater than anticipated. Payments were expected to be reduced by $103 billion over 5 years, yet estimates are now 86% higher—$191.5 billion—than originally anticipated. Academic health centers treat the most severely ill patients and care for the poor. The AOA believes such cuts will threaten the survival of teaching hospitals and their programs of graduate medical education.

Sustainable Growth Rate: The AOA urges Congress to fix the sustainable growth rate system. The AOA recently wrote to HCFA expressing our concerns about the instability of the current SGR system. We believe the following legislation action should be taken:

(1) Congress should create an add-on to the SGR formula to allow for technological changes in medicine that increase the demand for physician services;

(2) Congress should create an add-on to the SGR formula to account for the rising cost of ambulatory care practice with the shift in care from hospital inpatient settings to outpatient settings.

(3) Congress should instruct the administration to periodically adjust the SGR to allow for changes over time in the characteristics of patients enrolling in Medicare+Choice plans compared with those remaining in the fee-for-service program.

(4) Congress should raise the lower limit on SGR updates to provide a more acceptable payment floor for the updates.

(5) Congress should eliminate SGR projection errors by either giving the administration the authority to change projections as new Gross Domestic Product data becomes available or by requiring the administration to update the SGR using actual GDP data.

Resource-based Practice Expense: We are pleased with the progress that has been made on refining the Practice Expense Relative Value Units as mandated by BBA 97:

In the Medicare physician fee schedule proposal, HCFA has made improvements in its methodology, providing an opportunity for commenters to recommend corrections in code level practice expense RVUs for the year 2000.

HCFA should continue to work in cooperation with the RUC/PEAC process to ensure that the most accurate data is available and used to refine the practice expense RVUs. The AOA strongly supports bringing specialties together to work on the refinement process.

In addition, HCFA proposes to remove the physicians' clinical staff time in the facility setting from the raw CPEP data used in calculating the practice expense payment for any service. AOA agrees that Medicare should not pay twice for a service. However, we do believe staff time in the office—such as a nurse counseling a family; billing; time spent with managed care companies—should be recognized and accounted for in the practice expense. HCFA should establish a mechanism to recognize those costs related to staff time in the office. In addition, the AOA believes that further study may be necessary to resolve the issue of practice expense payment for the physicians' clinical staff time in a facility setting.

The AOA appreciates the opportunity to submit testimony and the attention the Subcommittee is giving to the refinement and correction of Medicare provisions in BBA.

[Attachments are being retained in the Committee files.]

Statement of American Physical Therapy Association, Alexandria, VA

Mr. Chairman and Members of the Subcommittee on Health, on behalf of the more than 70,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit this statement for your consideration as you re-examine Medicare provisions contained in the Balanced Budget Act of 1997. APTA commends the Committee on holding a hearing on this important subject and appreciates having the opportunity to comment.

Most Americans will probably need physical therapy services at some time during their life. As people grow older, they may suffer a stroke, break a hip, or sustain

other traumatic injury. Many of these illnesses and injuries occur unexpectedly and require physical therapy services, which enable people to return to home, to work, to school, or to an active retirement. If Medicare beneficiaries receive these services on a timely basis, they are able to obtain maximum independence and increase the quality of their life.

The BBA significantly changed Medicare payment policies for rehabilitation services. These changes have had a detrimental impact on the ability of Medicare beneficiaries' access to quality physical therapy services. Ultimately, they could result in increased Medicare spending. This testimony will focus on three of the payment policy changes in the BBA, which have had a major impact on the ability of Medicare beneficiaries to receive quality physical therapy services. These include: (1) the $1500 cap on outpatient rehabilitation services; (2) the skilled nursing facility prospective payment system; and (3) the home health agency prospective payment system.

Background

Prior to the BBA of 1997, Medicare reimbursement for physical therapy services varied, depending on whether the services were covered under Part A or Part B, and depending on the setting in which the services were furnished. Skilled nursing facilities, rehabilitation hospitals/units, home health agencies, CORFs, and rehabilitation agencies were reimbursed under a retrospective cost-based system. Physical therapists in private practice were reimbursed under the physician fee schedule.

The BBA made significant changes to Medicare payment policies for rehabilitation services. Under the BBA, beginning January 1, 1999, an annual $1500 per beneficiary cap per year for physical therapy (including speech language pathology services) and for occupational therapy will be imposed on Medicare beneficiaries receiving outpatient rehabilitation services. In addition, skilled nursing facilities furnishing services under a Part A stay are reimbursed according to a new prospective payment system, beginning July 1998. CORFs, home health agencies (Part B), SNFs (Part B), rehabilitation agencies, and outpatient hospital departments are reimbursed under a fee schedule, beginning January 1, 1999.

These drastic changes, which will be discussed in further detail in the paragraphs that follow, occurred at the same time. Thus, providers did not have much time to prepare for them. Further, there was no opportunity to determine whether any of these changes alone would have brought about the necessary reductions in Medicare payment. For example, changing from a cost-based system to a fee schedule for outpatient therapy servings may have resulted in considerable savings that would have made the $1500 cap unnecessary.

$1500 Cap on Outpatient Physical Therapy Services

The Balanced Budget Act (BBA) of 1997, amended section 1833(g) so that beginning January 1, 1999, an annual $1500 per beneficiary cap per year, per therapy will be imposed on Medicare beneficiaries receiving outpatient rehabilitation services furnished by physical therapists in independent practice (PTPPs), rehabilitation agencies, Comprehensive Outpatient Rehabilitation Facilities (CORFs), skilled nursing facilities (SNFs), and physicians' offices. The $1500 cap does not apply to physical therapy services furnished in outpatient hospital departments. In regulations issued by HCFA, two caps are established: (1) $1500 per beneficiary per year for physical therapy and speech therapy combined; and (2) $1500 per beneficiary per year for occupational therapy.

A. The Cap Is Insufficient to Cover the Costs of Therapy

APTA strongly opposes the imposition of a $1500 cap on therapy services. APTA believes that this cap will have a detrimental impact on Medicare beneficiaries who need physical therapy services beyond the arbitrary $1500 limit. The ability of Medicare beneficiaries to receive the necessary physical therapy services under the $1500 limit is further exacerbated by grouping speech therapy and physical therapy together under one $1500 cap. In its June report to Congress, the Medicare Payment Advisory Commission (MedPAC) stated that in 1996 "Physical therapy accounted for 70% of outpatient therapy payments. Occupational therapy and speech pathology made up 21% and 9% of payments, respectively." [1]

Documents produced by APTA and the Medicare Payment Advisory Commission (MedPAC) indicate that $1500 per beneficiary per year is insufficient to cover the

[1] Report to the Congress: Context for a Changing Medicare Program, Medicare Payment Advisory Commission, June 1998, p. 82.

costs of physical therapy for certain diagnoses. In November 1997, the APTA published The Guide to Physical Therapy Practice, Part II: Preferred Practice Patterns (hereinafter referred to as the "Guide"), that shows the impact that the $1500 cap will have on beneficiaries in need of physical therapy. The Guide, which was developed by expert panels of physical therapists, contains preferred practice patterns describing common sets of management strategies used by physical therapists for selected patient/client diagnostic groups. The Guide classifies patients by impairments and diagnostic groups, identifies the range of current options for care, and approximates the expected range of number of visits per episode of care for these patient groups. The Guide shows which conditions require extensive physical therapy treatment. They include: individuals recovering from a stroke, lower extremity amputation, hip replacement, and Parkinson's disease to name a few. A chart, highlighting the mid-range of physical therapy visits necessary per episode of care is attached.

MedPAC analyzed the impact of the coverage limits and presented the results of this analysis in its June 1998 report to Congress. MedPAC examined the 1996 claims of patients treated in rehabilitation agencies and CORFs who incurred payments that exceeded the $1500 coverage limit. The Commission found that about 1/3 of patients in rehabilitation agencies and CORFs exceeded either $1500 of outpatient physical and speech therapy or $1500 of occupational therapy. MedPAC found that some types of patients were more likely to exceed the dollar limit than others. For example, half of the stroke patients served in these settings exceeded the cap.

President Clinton, considerably younger than Medicare eligibility age, suffered a knee injury, had surgery and underwent extensive physical therapy for 3–4 months. Had he been a Medicare beneficiary, the President's care would have exceeded the $1500 cap after 2–3 weeks of care. As of result of his physical therapy, the President has resumed full functional activities.

B. The $1500 Cap will disrupt the Continuum of Care

This payment policy will disrupt the continuum of care. Patients will be forced to change treatment settings to an outpatient hospital once the cap has been reached in a non-outpatient hospital setting. Rather than saving money for the Medicare program, this policy only redirects the patient to receive care in an outpatient hospital department. Many beneficiaries, particularly in rural areas, may have difficulty obtaining access to needed physical therapy services because they would have to travel a considerable distance to reach a hospital.

Skilled nursing facilities will have two methods of reimbursement, depending on whether the patient's stay is being covered by Part A or Part B. If the patient is under Part A, therapy services will be reimbursed under a prospective payment system. Under this system, the SNF receives a per diem payment for each patient, which varies depending on which of the 44 resource utilization groups (RUG) the patient is classified. For Part B Medicare patients (when the patient has exceeded the 100 day part A stay), the skilled nursing facility will receive payment under the physician fee schedule for therapy services and the $1500 cap will apply. This system is confusing to the skilled nursing facility and the patient and disrupts patient care.

Further, Medicare beneficiaries in skilled nursing facilities that are receiving Part B benefits will probably be unable to receive physical therapy services once the cap has been reached. In the SNF PPS regulations issued in July 1999, HCFA requires that SNFs bill for all therapy services and states that a SNF resident may not go to an outpatient hospital department to receive therapy services once the $1500 limit has been exceeded. Therefore, SNF residents will be unable to receive these services without paying out-of-pocket.

C. The $1500 cap will be difficult to administer

In addition to having an adverse impact on Medicare beneficiaries, the $1500 cap will also be extremely difficult for HCFA to administer. It will be an administrative nightmare for HCFA to determine whether a Medicare beneficiary has exceeded the $1500 cap. For example, a physical therapist in private practice will have difficulty determining whether a beneficiary has already received $1500 of outpatient therapy services in a skilled nursing facility. In addition, if the beneficiary resides in New York for part of the year and Florida for the remainder of the year, it may be difficult for the therapist in Florida to know that the beneficiary had already received services in New York. The fact that skilled nursing facilities, CORFs, rehabilitation agencies, and private practitioners may submit different billing forms or have different timing for submission of their bills will also result in administrative problems in tracking whether the cap has been met.

According to the BBA, HCFA shall "submit by January 1, 2001 a report to Congress including recommendations on establishment of a revised coverage policy for therapy services based on classification of individuals by diagnostic category and prior use of services in place of the dollar limits." APTA supports a coverage policy based on patient resource utilization rather than caps.

APTA recommends that Congress repeal the $1500 cap on outpatient therapy services. If the cap is not repealed, Congress should establish exceptions to the cap. A bill, titled, "The Medicare Rehabilitation Benefit Improvement Act of 1999 (H.R. 1837 and S.427), which was introduced in Congress, gives the Secretary of the U.S. Department of Health And Human Services the authority to establish exceptions to the current cap. The bill would address some of the problems that have been caused by the $1500 cap by providing an exceptions process for the medically complex and frail patients. According to the legislation, a Medicare beneficiary would have to meet one of the following requirements to receive an exception to the cap: (1) Be subsequently diagnosed with an illness, injury or disability that requires additional medically necessary rehabilitation services; (2) need more extensive rehabilitative services due to an additional diagnosis or incident that worsens the beneficiary's condition; (3) be hospitalized if further rehabilitation services are not provided; or (4) meet other criteria determined by the secretary of HHS. APTA urges members of Congress to support this legislation. Passage of this legislation will help to ensure that patients who are in need of outpatient therapy services receive appropriate care.

It is APTA's view that the amount of physical therapy that the patient receives should not be contingent upon the practice setting. Patients should receive the appropriate level of care at the appropriate site of services that is based on medical and functional need and not on economic incentives or disincentives.

Skilled Nursing Facility Prospective Payment System

The BBA reduced skilled nursing facility payments by $9.5 billion over five years and required the Health Care Financing Administration (HCFA) to implement a prospective payment system (PPS) by July 1, 1998, for skilled nursing facilities (SNF's). We believe that the prospective payment system can improve the cost efficiency of the Medicare program if implemented appropriately.

Under the PPS, a per diem payment is made to the SNF to cover the routine, ancillary and capital costs incurred by the facility during the patient's stay. One of the most critical issues in developing a prospective payment system is developing a case-mix measure that will be used to ensure that a facility is paid sufficiently for the resources necessary to provide appropriate care. If appropriate payment rates are established, patients will have access to medically necessary care of high quality. If inadequate rates are established, patients will experience difficulties in obtaining services.

In developing the per diem rates, HCFA included costs related to nursing and social services salaries and total costs of non-therapy ancillary services in the nursing case mix. Because the non-therapy ancillary services, such as wound care, enteral nutrition, and pharmaceuticals, were treated as a direct pass-through under the Multi-State Case Mix and Quality Demonstration, HCFA did not have information on the amount of these services that a resident in a particular RUG–III group would receive. The case-mix weights only capture variations among RUGs groups in anticipated costs for nursing and therapy staff time. The differences in resource utilization for the other ancillaries are not reflected in the therapy or nursing case mix weights and are not captured in the non-case mix component of the payment. Therefore, the facility receives the same amount for the non-case mix component regardless of the RUGs–III grouping.

The residents in the different groups may vary in their use of other ancillary services and supplies, such as wound care, lab tests and pharmaceuticals. Thus, the new PPS fails to adequately account for differences in costs associated with the care of medically complex patients. According to preliminary research from HCFA, patients in two RUGs categories, "extensive services" (which includes patients who need IV feeding, IV medications, or require ventilators) and "special care" (which includes patients with MS or CP) have much higher non-therapy ancillary costs than other patients.

In our view, these issues can be addressed by revising current case-mix (Resource Utilization Groups) categories used in the new SNF PPS to account for these medically complex patients. Unfortunately, HCFA cannot make any changes to case-mix until after 2000 because of the year 2000 computer problems.

Problems arise for Medicare patients, particularly those who have complex medical conditions requiring extensive nursing care, rehabilitation and respiratory ther-

apy and substantial use of pharmaceuticals, specialized medical treatments and other non-therapy ancillaries. It is a serious problem if SNF PPS payment rates are insufficient to cover the costs of severe, medically complex patients who incur significantly higher costs. In addition, APTA is concerned that resources provided through the established RUG system for necessary physical therapy services are being utilized to offset losses relating to RUG payment for other services and items. APTA is wholly opposed to this practice.

APTA supports utilizing a multiplier to increase the payments for the extensive services and special care RUGs groups, until the final case-mix improvements can be made by HCFA. It is clear that payment for these categories is inadequate related to the costs associated with treating these individuals. Once the Secretary refines case-mix and the funding, the multiplier may no longer be necessary.

Recent OIG Reports

APTA supports the overall findings of the U.S. Health and Human Services' Office of the Inspector General (OIG) in reports issued recently regarding physical therapy and occupational therapy services provided in skilled nursing facilities (SNFs).

In its report titled "Physical Therapy and Occupational Therapy in Nursing Homes: Medical Necessity and Quality of Care," the OIG found that 83 percent of therapy provided in nursing homes was medically necessary and that most patients would not have achieved similar outcomes without therapy. However, 13 percent of therapy was billed improperly to Medicare because the therapy was not medically necessary or was provided by inappropriate staff. Another 4 percent of therapy was not documented in the patient's medical record. The OIG noted that some of these problems resulted from a lack of awareness and understanding of the Medicare coverage guidelines and criteria.

The OIG recommended more training for skilled nursing facilities and therapy staff on guidelines, coverage criteria, local medical review policies, and monitoring procedures. APTA supports this OIG recommendation and is eager to work with the Health Care Financing Administration (HCFA) to provide such training.

APTA has worked diligently to enhance the documentation skills of its members, an effort that has been commended by the Office of the Inspector General. Physical therapy documentation practices need to be improved in the skilled nursing home environment. Awareness and understanding of Medicare coverage guidelines is essential and it is the professional responsibility of physical therapists and physical therapist assistants in skilled nursing facilities to be aware of these guidelines.

The OIG report titled "Physical and Occupational Therapy in Nursing Homes: Cost of Improper Billings to the Medicare Program," it was reported that $145 million was spent on services provided by inappropriate personnel. The quality of care beneficiaries received from those individuals must be in question, and should be address by this Congress.

The OIG study, which was conducted before the implementation of the prospective payment system (PPS) for skilled nursing facilities (SNFs), also found that assistants and aides provided care that is above their level of expertise, education, and training. APTA has long opposed the use of inappropriate staff to provide services. The 1999 APTA House of Delegates reaffirmed that position in an action stating that, "Physical therapists are the only professionals and physical therapist assistants, under the direction of the physical therapist, are the only paraprofessionals who provide physical therapy interventions."

APTA cautions that the SNF PPS encourages facilities to provide care by the least expensive means. APTA is, therefore, concerned that the PPS may be facilitating, instead of correcting, this behavior. APTA is eager to address the issues brought forth in the OIG reports and to work with Congress and the HCFA to ensure that beneficiaries receive high quality care in skilled nursing facilities.

Home Health PPS

The BBA required HCFA to establish a PPS for home health services and implement the system beginning October 1999. In addition, if the PPS is not implemented by that date, home health agency payments would be reduced by 15%. In the interim, home health agencies are reimbursed under an interim payment system established by the BBA. Because of problems associated with the IPS, Congress later passed legislation mandating that the home health agency PPS be implemented by October 1, 2000 and delayed the 15% across the Board reductions until that date.

APTA urges Congress to ensure that HCFA implements a PPS system by the deadline. Under the current interim payment system, HHAs are experiencing significant reductions in payment, which are impacting beneficiaries access to services. HCFA estimates that the IPS system will result in a decrease in payments to home

health agencies of $1.06 billion in 1998 and $2.14 billion in 1999 compared to payment that would have been made if it were not enacted. This is approximately a 9% reduction. In determining this reduction, HCFA accounts for changes in the HHAs behavior, which might include increasing the number of low cost beneficiaries served, decreasing the number of visits provided, and discharging patients earlier.

APTA is concerned that due to the low reimbursement rates, home health agencies will be forced to cut costs by reducing the amount of therapy and other services that Medicare beneficiary receives, despite the fact that those services are medically necessary. In addition, it is difficult for HHAs to obtain physical therapists to furnish services in rural areas, and as a result, the HHA has to pay higher salaries to these therapies. Because the HHAs are receiving significantly lower reimbursement under the new IPS, they may have difficulty recruiting therapists in these rural areas. To further reduce the IPS system payments by an additional 15% would exacerbate the problems cause by the IPS and would prevent Medicare beneficiaries from receiving much needed rehabilitation services that would enable them to function independently.

APTA urges Congress to ensure that the home health agency PPS is implemented as scheduled in October 1999 and that payment rates are set appropriately under the PPS. In addition, HCFA should consult the rehabilitation industry as they develop this system.

Home Health Oasis

On January 25, 1999, the Health Care Financing Administration (HCFA) published an interim final rule titled: "A Reporting Outcome and Assessment Information Set (OASIS) Data as Part of the Conditions of Participation for Home Health Agencies." This rule revises the existing conditions of participation for home health agencies. The rule requires that home health agency (HHA) health care providers complete a comprehensive assessment for each patient and that they incorporate the OASIS into the process.

OASIS is a lengthy, complex assessment tool. APTA believes that these and other design flaws must be addressed in order for OASIS to be an affective assessment tool. APTA wishes to work with Congress and the HCFA in refining OASIS.

Physical Therapists in Private Practice

Another HCFA payment policy, which has further exacerbated the impact that the BBA has had on therapy services relates to supervision of physical therapists assistants, who render services in private practice settings. In the November 1998 final physician fee schedule rule, HCFA revises section 410.60 of the regulations to state that in private practice physical therapy office, assistants and aides would have to be personally supervised by the therapist and employed directly. HCFA further defines personal supervision to require that the therapist be in the room during the performance of the service.

APTA believes that the supervision requirement of physical therapist assistants in the private practice setting should be direct supervision rather than personal supervision. Direct supervision requires that the physical therapist be on the premises when services are furnished by the assistants, but not in the room. It is not necessary for the physical therapist to be in the same room as the assistant for services to be safely and effectively delivered.

Physical therapist assistants are recognized practitioners under Medicare and are defined in the regulations at 42 CFR §485.705(c). According to this provision, a physical therapist assistant is "a person who is licensed as a physical therapist assistants by the State in which he is practicing, if the State licenses such assistants, and has graduated from a 2-year college-level program approved by the American Physical Therapy Association." APTA defines physical therapist assistants as a "technically educated health care provider who assists the physical therapist in the provision of physical therapy. The physical therapist assistant is a graduate of a physical therapist assistant associate degree program accredited by an agency recognized by the Secretary of the United States Department of Education or the Council on Postsecondary Accreditation." Attached are APTA's Guidelines on Direction, Delegation, and Supervision in Physical Therapy Services, which provide these definitions.

Physical therapist assistants have the education and training to perform services without a physical therapist being in the room. As stated earlier, for Medicare to reimburse for the services of a physical therapist assistant, the physical therapist assistant must have graduated from a school of physical therapy approved by the American Physical Therapy Association. To be accredited by APTA's Commission on Accreditation in Physical Therapy Education (CAPTE), programs must include a

comprehensive curriculum, which makes the graduate competent to furnish services. Attached are the evaluative Criteria for Accreditation of Education Programs for the Preparation of Physical Therapist Assistants, which include a description of the curriculum for PTA schools.

Requiring personal supervision of assistants, would also be contrary to state laws, which do not require that a physical therapist be present in the room when supervising a physical therapist assistant. In addition, in many other Medicare settings, such as SNFs, home health agencies, and rehabilitation agencies, the supervision requirement of PTAs is general supervision, meaning the physical therapist does not have to be on the premises when the PTA is furnishing services. Attached is a chart summarizing Medicare regulatory requirements for supervision of physical therapist assistants in rehabilitation agencies, CORFs, home health agencies, inpatient hospitals, outpatient hospitals, physical therapists in private practice, physician's offices, and skilled nursing facilities. A copy of Medicare regulations and laws related to supervision accompany the chart.

Requiring direct supervision would be consistent with the supervision requirement for assistants that PTPPs were required to meet in the past under section 410.60(a)(3)(ii) of the Medicare regulations. Prior to January 1999, section 410.60(3)(ii) of the regulations stated that outpatient therapy services are covered if they are furnished, "by or under the direct supervision of a physical therapist in independent practice who is licensed by the State in which he or she practices. . . ." Section 486.151 also reiterated that "services must be furnished by or under the direct supervision of a qualified physical therapist in independent practice." Further, section 2215 of the carriers manual (Service Furnished by Physical or Occupational Therapist in Independent Practice) states the following:

> Nature of Covered Services: To be covered as physical therapy, services must be the type and be rendered under the conditions specified in section 2210. The services must be provided either by or under the direct personal supervision of the therapist in independent practice and the services of support personnel must be included in the therapist's bill . . .

Section 2050.1 of the carriers manual, which relates to a physician billing services as incident to, states that "coverage of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct personal physician supervision. It further defines the term direct personal supervision as follows:

> *Direct personal supervision* in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing service.

In response to APTA's comments regarding this issue, in the November 1998 final fee schedule rule, HCFA states "We do not believe that we have the authority to modify the supervision requirements for therapy (physical, occupational or speech-language pathology) assistants and aides. Therefore, we are maintaining our current requirement that therapy assistants and aides have to be personally supervised by the therapist and employed directly by the therapist, by the partnership or group to which the therapist belongs." (63 Fed Reg 58870). This provision clearly changes HCFA's policy with respect to supervision in the private practice setting. Furthermore, the language in the Federal Register, indicates that the decision to change the supervision requirement from direct personal supervision (as defined on the premises or in the suite) to personal supervision (in the room) was based upon inaccurate information.

We request that you urge HCFA to clarify that the supervision requirement for physical therapist employed in private practice setting should be direct supervision. This would mean that the physical therapist must be present in the office suite and immediately available to provide assistance and direction throughout the time the assistant is performing the service.

Conclusion

As your Committee examines the impact of the BBA on patient care, you should ensure that Medicare beneficiaries have access to the physical therapy services that they require. This can be accomplished by: (1) repealing the $1500 cap on therapy services; (2) ensuring appropriate payments rates under the SNF PPS for medically complex patients; and (3) establishing a home health PPS based on sufficient payment rates and case mix methodology. While we have only touched upon a few areas of concern, the APTA recommends that you strive to ensure that payment methodologies do not dictate patient care. It is our hope that any Medicare reforms will

enable Medicare beneficiaries to receive necessary physical therapy services in an efficient, cost-effective manner.

Statement of American Society for Gastrointestinal Endoscopy, Manchester, MA

The American Society for Gastrointestinal Endoscopy (ASGE) is pleased to submit the following recommendations for the Subcommittee's consideration as it reviews possible modifications to Medicare provisions in the Balanced Budget Act of 1997 (BBA '97). ASGE represents the more than 6500 physicians who specialize in the use of endoscopy to diagnose, treat and manage digestive diseases and conditions.

These changes represented one of the most significant overhauls of the Medicare program in many years. Congress initiated major revisions in Medicare's structure and payment policies, including coverage of colorectal cancer screening and other preventive benefits, changes in payment for physicians' practice expenses, and establishment of a prospective payment system for hospital outpatient department services, along with many other provisions. The Subcommittee is to be commended for initiating this review of the impact of BBA '97 in order to evaluate whether or not the modifications are having negative impacts on health care delivery for Medicare beneficiaries. If the subcommittee determines that changes are required, ASGE urges quick action on them.

ASGE has recommendations in three areas: colorectal cancer screening, practice expense payments and the rules governing payments for hospital outpatient departments and ambulatory surgery centers.

Colorectal Cancer Screening

The preventive services provisions of BBA '97 represented a major step forward in Medicare coverage of preventive care. ASGE particularly supports the coverage of colorectal cancer screening because it is a proven service that saves lives. Public understanding of the importance of screening for this cancer has grown dramatically and physicians are receiving more and more requests from patients for the service. In fact, many practices have waiting lists of people who want to be screened for this cancer.

Historically, many gastroenterologists and other physicians trained in endoscopy have taught their nurses how to perform simple colorectal cancer screening using a flexible sigmoidoscope. There is ample research showing that nurses can perform this service safely and effectively. However, under current Medicare law and regulation, there is no way to pay for this service when performed by a nurse. ASGE recommends that this situation should be changed to include trained registered nurses in the universe of providers eligible for Medicare reimbursement for flexible sigmoidoscopy for colorectal cancer screening.

ASGE and representatives of the Society of Gastrointestinal Nurses and Associates met with HCFA to discuss this problem and presented the scientific data documenting the appropriateness and safety of nurses performing screening sigmoidoscopy. We were advised that the payment limitation was a function of the statutory language adopted in 1997 and that HCFA had no authority to allow reimbursement for this service when performed by nurses.

This limitation has no relationship to the training and skills of nurses and is an artificial barrier to the most cost-effective provision of these crucial screening services. ASGE urges the Subcommittee to amend the BBA '97 colorectal cancer screening provisions to allow reimbursement when appropriately trained nurses perform flexible sigmoidoscopy for screening purposes.

Payment for Practice Expenses

The move to resource based practice expense relative values in the Medicare physician fee schedule is having a significant impact on our members, and many other physicians, as we see a tremendous shift of reimbursement dollars from hospital and ambulatory surgery center services to services in the physician office setting.

The implications of this transfer for our members and their patients are not completely clear, but they could be significant and possibly harmful to best medical practice. ASGE has for years recommended that all settings where GI endoscopy is performed meet equivalent safety standards. Few physicians' offices meet those criteria. There are many sound medical and safety reasons why GI endoscopy is not

common in the physician office, and financial incentives that might change that situation should be viewed with caution.

Lack of Refinement as Required by BBA '97

Any payment system that has the potential to reduce practice expense payment by nearly 70% for complex medical and surgical procedures performed in the hospital requires careful review and refinement. In fact, the BBA, which laid out the current framework for revising the calculation of practice expense relative values, requires HCFA to conduct a refinement of these values each year during the transition from the old values to the new ones. ASGE is very concerned that HCFA is not meeting that schedule and that the opportunities created by the statute for refinement and transition are being lost.

In the fall of 1998 HCFA published its final rule implementing the first phase of the Balanced Budget Act practice expense provisions. The agency identified more than 25 issues of data and methodology that required further attention and indicated that it would deal with them in the refinement process. HCFA stated that it would hire a contractor to advise agency staff on the many complex questions that remained. Some of these, like the question of how new data would be entered into the system, are critical to the future use of resource based practice expense relative values.

The proposed rule released in July does not address most of these matters. In fact, HCFA has only recently hired a contractor with expertise to assist the agency with refinement issues. The contractor is not expected to make a final report before May 2001. Thus, the earliest any significant refinement of the practice expense values could be achieved is 2002, after the transition has ended. It is quite possible the implementation of refinements could extend beyond that point. Therefore, we have urged HCFA to continue to consider all practice expense relative values as interim until all the refinements are complete, even beyond 2002.

Clinical Staff Time

HCFA did attempt one refinement of significance in its recently proposed rule affecting the use of clinical staff when services are provided outside the physician office, but the controversy surrounding that proposal highlights the difficulties facing the agency as it tries to move forward.

The issue of clinical staff time has its roots in the earliest efforts to capture data on physician practice expenses. Several specialties, including cardiothoracic surgeons, cardiologists and ophthalmologists, indicated that they frequently brought their own staff to the hospital to assist with surgery and patient rounds. They argued that these expenses needed to be included in HCFA's database that would be used to calculate the practice expense relative values.

In the proposed rule, HCFA addressed this question again and eliminated these expenses. HCFA also published its estimates of the impact of this decision on the various specialties. Not surprisingly, the practice expense payments for cardiothoracic surgeons declined even more than was previously estimated. However, the GI community was stunned when HCFA estimated that its Medicare payments would drop another 2% as well. Since gastroenterologists have not argued that they take their own staff to the hospital, they could not understand why their payments would be reduced by HCFA's policy decision. It turns out that HCFA not only eliminated costs associated with clinical staff brought to hospitals, but also costs associated with clinical staff who support a hospital service from the office setting. This includes, for example, costs such as providing patient instructions for the procedure, providing the results to the patient and/or the family, and other similar clinical interactions.

ASGE objects to this action. HCFA is required to "recognize all staff, equipment, supplies, and expenses" in developing new resource based practice expense relative value units. When HCFA began its data collection efforts, physicians were specifically asked to identify the amount of time that clinical staff spent on hospital based services. If HCFA disputes these answers now, then it should develop a process for reviewing that information with the physician community. The newly hired contractor should be asked to advise HCFA on how to address this question. Likewise the contractor should be directed to review the circumstances under which some physicians may bring their own staff to the hospital. This entire matter is clearly one that should be subject to the refinement process and not subject to a unilateral decision that further depresses payments for services performed in the hospital. We have urged HCFA to delay this action until input has been received on this issue from the American Medical Association's Relative Value Update Committee, the newly established multispecialty Practice Expense Advisory Committee and HCFA's own outside expert.

Site of Service Differential

HCFA has for many years applied a site of service differential in Medicare physician payments, creating differing levels of payment for practice expenses when a service is performed in the physician's office and when the same service is delivered in a hospital or ambulatory surgery center. The theory is that a physician incurs greater practice expense when providing the service in the office where the physician must carry all the overhead costs compared to performing the same service in the hospital where the institution may bear some of these costs. Our concern is not with the theory, but with its application. The differential in payment between these settings is significant, and may be large enough to encourage physicians to perform more and more GI endoscopy in the unregulated office setting. Since all but the simplest endoscopic procedures require the use of anesthesia, usually conscious sedation, ASGE believes that the office is an inappropriate site of service unless the office demonstrates it meets the same standards as ambulatory surgery centers or hospital outpatient departments. Few physician offices can meet this standard, and we see no willingness by HCFA to begin requiring that physician offices meet these requirements.

We are not alone in this concern. The Florida Board of Medicine is now reviewing a proposed rule that would require the presence of an anesthesia-trained third party to administer office-based anesthesia. California has acted legislatively to address this same problem. These states recognize that there is risk to patients in the unregulated use of anesthesia in the physician office and are taking steps to protect patients.

ASGE believes that HCFA should do no less. HCFA's prior rules on the site of service differential required that a procedure be performed at least 50% of the time in the physician office setting before any payment differential would be applied. This simple formula assured that the use of a procedure in the office was well accepted before a payment differential was established. When HCFA used panels of experts to develop the original cost estimates for practice expenses, a 10% threshold was adopted. These panels would not consider costs in the office setting unless there was evidence that the procedure was performed in the office at least 10% of the time. HCFA's current rule has no explicit threshold. Most of the GI endoscopy procedures that are subject to the site of service differential are performed in the office 10% or less on average, according to HCFA data.

ASGE believes that HCFA's current application of a site of service differential sends the message that the federal government believes that these procedures are appropriately performed in the unregulated office setting. This is the wrong message.

If HCFA does not want to set a simple threshold for the application of the site-of-service rule, such as 25%, then it may wish to consider the recommendation of the Medicare Payment Advisory Commission (MedPAC). In its report to Congress this year, MedPAC recommended that "decisions regarding the applicability of the site-of-service differential should reflect a clinical consensus about the settings in which specific services should be provided." That would also be a sensible way to resolve this issue, one that is consistent with the standard of care in each specialty. At the present time, the consensus among the national gastroenterology organizations is that HCFA's action is not correct. It would require little effort to work with the interested specialty societies to clear up this situation and would reduce the possibility of unintended consequences for patient care. ASGE has previously recommended that this site of service rule be changed to better reflect an appropriate standard of medical care. We have urged HCFA to either apply a reasonable threshold to the application of a site of service differential or adopt MedPAC's recommendation. HCFA should then recalculate the practice expense relative values based on this new standard.

What Should This Subcommittee Do?

ASGE is presenting these detailed comments to the Subcommittee to demonstrate the complexity of the effort to develop practice expense payments that realistically address the true costs of medical practice. This issue has been debated since 1992 when the physician fee schedule went into effect. HCFA has already spent years examining this problem and trying to collect data upon which to act. Now we have learned that the transition will likely be over before HCFA is prepared to act on needed refinements to data and methodology. The investment of seven years and untold taxpayer dollars has produced little. Even if HCFA accepted the recommendations we have just outlined, significant problems remain with the entire enterprise.

ASGE believes that the time has come to reexamine the decision to move to resource based practice expense relative values. We do not believe that HCFA has the resources to address refinement questions promptly. Given our present limited knowledge and federal resources, it is unlikely that we can ever develop real confidence in the practice expense relative values. If there is no shared confidence in the values, how can Congress or the public be assured that the massive changes in payment that are now underway are justified and will cause no harm? The reimbursement shifts now underway affect all medical services provided outside the physician office and particularly impact the nation's tertiary care and teaching hospitals which often specialize in the very kinds of medical and surgical procedures most hard hit by these changes.

ASGE appreciates the leadership of the Subcommittee during the debate over practice expenses in 1997. The changes incorporated in the BBA were an honest attempt to clarify HCFA's instructions and get the entire process back on track. However, ASGE must ask this Subcommittee to act again on the practice expense issue. It is time to recognize the limitations of data and methodology that undermine confidence in the physician fee schedule and to place reasonable limits on the changes that will result from this exercise. Given the lack of data, no practice expense relative value should be reduced by more than 20 percent from its 1997 level, the last year before the practice expense transition began. For the same reasons, no practice expense relative value should increase more than 200% over its 1997 level. This upper boundary still allows for significant adjustments in payments for evaluation and management codes, but eliminates some of the more inexplicable changes (like a more than 400% increase in the practice expense values for ear wax removal) that have been produced by this effort.

Even with these limits, the values would still be more resource based than their predecessors would because HCFA has used the American Medical Association's survey data on physician practice costs as the starting point for its work. The policy of increasing payment for evaluation and management codes that were regarded as undervalued by many physicians would also be achieved.

However, setting these limits would protect against unpredictable and undesirable shifts in physician and hospital behavior that could result from the dramatic reductions in payments for services provided in hospitals and other settings outside the physician office.

Payments in the Hospital Outpatient Department and the Ambulatory Surgery Center

Congress directed HCFA to develop a prospective payment system for the hospital outpatient department. A mechanism has been proposed, but it has raised substantial concerns among hospitals and physicians because of the reductions in payment that would result from its implementation. MedPAC has recommended that HCFA proceed with caution and evaluate alternative systems.

As this process has been under development, HCFA has also announced a new payment methodology and rates for ambulatory surgery centers (ASCs). Using data from 1993 HCFA has proposed major revisions and reductions from current payment levels. We estimate that payments for centers that specialize in GI endoscopy would decline by 14%.

Almost all complex GI endoscopic services are provided in either the hospital outpatient department or the ambulatory surgery center. ASGE is very concerned that the payment proposals now under review will significantly affect the ability of these facilities to provide the kinds of staff and technological support that are needed to assure the best outcome for the patient. We are particularly troubled that HCFA's data supporting the action on the ASCs are so flawed. Not only is it old, it is very incomplete. HCFA had to extrapolate more than half the payment rates because of inadequacies in the database.

HCFA is now finalizing the 1999 ASC cost survey. ASGE has reviewed the document and finds it much improved over the earlier survey form. We believe that HCFA should delay action on the ASC proposed rule until the new data are available. Since there is no statutory mandate or deadline for action on ASC payments, there should be no reason not to delay the rule in order to get superior data.

We urge this Subcommittee to direct HCFA to delay the ASC rule until the data from the 1999 cost survey are collected and analyzed.

Conclusion

ASGE is encouraged by the Subcommittee's review of the Medicare provisions in the BBA '97. It is timely and appropriate. We urge careful consideration of our recommended changes as the Subcommittee continues its efforts.

Statement of Association of American Medical Colleges

The Association of American Medical Colleges (AAMC) is pleased to submit for the record testimony to the House Ways and Means Health Subcommittee on the need to provide teaching hospitals relief from further Balanced Budget Act of 1997 (BBA) Medicare reductions. The AAMC represents more than 300 of the nation's major teaching hospitals and health systems participating in the Medicare and Medicaid programs, including 70 Department of Veterans Affairs medical centers; the nation's 125 U.S. accredited allopathic medical schools; 16 accredited Canadian medical schools; nearly 90 academic and professional societies representing 75,000 faculty members; and the nation's medical students and residents.

The Role of Teaching Hospitals in America's Health Care System

Teaching hospitals have a unique role in our nation's health care system. In addition to providing basic health services to their communities, such as primary and secondary patient care, teaching hospitals have the additional societal responsibilities of providing: education for all types of health care professionals; an environment in which clinical research can flourish; and highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services. Teaching hospitals also provide a significant amount of indigent care. Because of their education and research missions, teaching hospitals offer the newest and most advanced services and equipment, and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. (Attachments 1 and 2 provide detailed information on the special characteristics of teaching hospitals.)

The Balanced Budget Act of 1997

The BBA made significant changes to the Medicare program, including major reductions in Medicare payments to hospitals. The BBA contains some of the most significant changes for teaching hospitals since the beginning of Medicare. Chief among the BBA's changes are Medicare reductions in special payments to teaching hospitals, known as the Indirect Medical Education (IME) adjustment and the Disproportionate Share Hospital (DSH) payment. DSH payments reimburse hospitals for caring and preserving access for low-income Medicare beneficiaries and indigent populations. While the IME payment carries a "medical education" label and reimburses teaching hospitals for the higher costs associated with physician training, the purpose of the IME payments is much broader:

This adjustment is provided in light of doubts . . . about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . . The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Rept, No. 98–25, March 4, 1983 and Senate Finance Committee Rept, No. 98–23, March 11, 1983).

In addition, the BBA makes significant changes to the outpatient payment system which will also significantly affect Medicare's support of teaching hospitals. The BBA's cuts to these three Medicare payment areas—IME, DSH, and outpatient—contribute to the disproportionate impact of the BBA on teaching hospitals (Attachment 3).

Medicare Indirect Medical Education Payments

The BBA reduces the Medicare Indirect Medical Education (IME) adjustment by 29 percent over four years. Specifically, the BBA reduced the IME adjustment from 7.7 percent to 7.0 percent in Fiscal Year (FY) 1998 and from 7.0 percent to 6.5 percent for FY 1999, and will lower the adjustment further to 6.0 percent in FY 2000 and 5.5 percent in FY 2001. This reduction represents an absolute cut in Medicare support rather than a reduction in the rate of growth. On average, the IME is the second largest inpatient payment loss for teaching hospitals. Only losses associated with the inflation update payment rates are higher. (Attachment 6). However, for many teaching hospitals, the IME represents the largest loss of dollars as a result of BBA reductions.

Medicare Disproportionate Share Payments

The BBA also disproportionately affects teaching hospitals through Medicare's reduction in DSH payments because two-thirds of Medicare DSH payments are paid to teaching hospitals. The BBA reduces Medicare's DSH payments by five percent over five years (one percent increment per year). Thus far, a two percent reduction has been implemented.

Medicare Outpatient Prospective Payment System

The Health Care Financing Administration (HCFA) estimates that the BBA's authorization of an outpatient prospective payment system (PPS) will reduce per year outpatient payments to teaching hospitals by 10.6 percent compared to current payment levels. Such reductions will be more than double the estimated per year losses for non-teaching hospitals. This new system will further worsen the gap between costs and payments for hospital outpatient services to Medicare beneficiaries. The Medicare Payment Advisory Commission (MedPAC) estimates that outpatient payments for major teaching hospitals will fall to less than 70 percent of costs when the outpatient PPS goes into effect.

The BBA's Impact on Teaching Hospitals

The AAMC has major concerns about the ability of teaching hospitals to support their education, patient care, and research missions in light of their current financial uncertainty. As the health care marketplace is becoming more price competitive, all payers—including private payers, Medicare and Medicaid—are reducing their payments to teaching hospitals. Teaching hospitals are no longer able to bill at rates that reflect the extra costs of their special missions and responsibilities. Such reduced rates have put the long-term viability of teaching hospitals and their special missions in jeopardy. Only two years into its five-year implementation, the BBA's damaging impact, coupled with current market place phenomenon, is causing an immediate financial crisis at many teaching hospitals across the country. Assuming the same inpatient volume and case mix of Medicare patients, the vast majority of AAMC-member teaching hospitals will receive less money from Medicare in FY 2000 than they did in FY 1997.

Total margin is an important financial performance measure that reflects total hospital revenues and costs associated with all inpatient, outpatient and non-patient care activities.

The AAMC has conducted an analysis of the BBA's current and projected financial impact on its members, known as the Council of Teaching Hospitals and Health Systems (COTH). The AAMC found that Medicare reductions resulting from the BBA could result in the median total margin for a typical major teaching hospital (defined as those that have 25 or more residents for every 100 beds) falling to zero by 2002. In 1997, the median total margin for a typical major teaching hospital was 2.9 percent compared to margins of 5.4 and 6.1 percent for other teaching and non-teaching hospitals respectively. In 2002, the median total margin is projected to drop to zero (Attachment 5). Half of all major teaching hospitals could face negative total margins by 2002 (Attachment 6).

Moreover, AAMC's analysis found that by 2002, a typical major teaching hospital will cumulatively lose $41.1 million in Medicare payments (Attachment 4). However, many AAMC members across the country are slated to lose much more.

The Lewin Group's analysis of total Medicare margins project similar, but sharper trends—a declining teaching hospital margin from 1.1 percent in 1998 to −8.0 percent in 2002 (Attachment 7).

As reported in newspapers across the country, many teaching hospitals have already reduced their work forces due to their dire financial circumstances. Left unchecked, the BBA's Medicare cuts to teaching hospitals could force some of the nation's teaching hospitals to reduce the scope of their special and unique community services. Teaching hospitals in every region of the nation are now considering scaling back such key community services as poison control centers, hospital services for the uninsured, clinical research activities and education and training for medical students and residents.

Legislative Solutions Providing BBA Relief to Teaching Hospitals

Because the future of these special missions is in jeopardy, the AAMC is asking Congress to provide financial relief from the BBA to teaching hospitals by changing the BBA's implementation of Medicare IME and DSH payment reductions and reforming the outpatient payment prospective system. Several bills granting BBA relief to teaching hospitals have been introduced in Congress. Specifically, the AAMC

supports the following recommendations to provide financial relief to teaching hospitals:

(1) Halt the Implementation of IME and DSH Cuts

• Freeze the BBA's reductions in Medicare IME and DSH payments at current levels.

(2) Reform the proposed Medicare Outpatient PPS:

• Eliminate the 5.7 percent overall reduction due to the beneficiary co-insurance calculation. 252 Representatives and 77 Senators have written to HCFA Administrator Nancy-Ann Min deParle suggesting that HCFA's proposed rule is inconsistent with Congressional intent.
• Establish a payment floor to limit losses for hospitals that incur large payment reductions under the new PPS.
• Address other associated policy changes, such as establishing outpatient IME and DSH adjustments.

(3) Pay Teaching Hospitals 100 Percent of Special Payments Associated with Medicare Plus Choice Enrollees

• Currently, DSH hospitals do not receive these important payments when they care for Medicare managed care enrollees because the payment is included in the calculation of the payment to the managed care plan and managed care plans are not required to pass this special payment along to hospitals.
• The BBA's gradual phase-in payment of both Direct Graduate Medical Education (DGME) and IME payments to teaching hospitals when they care for Medicare+ Choice (Medicare managed care) enrollees should be accelerated to 100 percent starting in FY 2000. Currently, the phase-in schedule for these payments over five years pays teaching hospitals amounts equal to 60 percent in FY 2000, 80 percent in FY 2001, and 100 percent in FY 2002.

The AAMC would be pleased to work with the committee to ensure the future viability of teaching hospitals and their patient care, education and research missions.

Major Teaching Hospital Characteristics

[Short-Term General, Non-Federal Hospitals, 1997]

	% of Major Teaching	% of All Hospitals
AIDS Inpatient or Outpatient Care	88	38
Cardiac Cath Lab	94	36
Open Heart Surgery	82	21
MRI	85	49
Trauma Center	75	23
Psych Outpatient	77	28
Organ Transplant	65	9

SOURCE: AAMC analysis of AHA Annual Survey of Hospitals, 1997 data.
NOTE: Major Teaching Hospitals are 277 members of the Council of Teaching Hospitals and Health Systems (COTH).

Major Teaching Hospital Characteristics

Short -Term General, Non-Federal Hospitals, 1997

	% of Major Teaching	% of All Hospitals
AIDS Inpatient or Outpatient Care	88%	38%
Cardiac Cath Lab	94%	36%
Open Heart Surgery	82%	21%
MRI	85%	49%
Trauma Center	75%	23%
Psych Outpatient	77%	28%
Organ Transplant	65%	9%

SOURCE: AAMC analysis of AHA Annual Survey of Hospitals, 1997 data.
NOTE: Major Teaching Hospitals are 277 members of the Council of Teaching Hospitals and Health Systems (COTH).

Major Teaching Hospital Characteristics

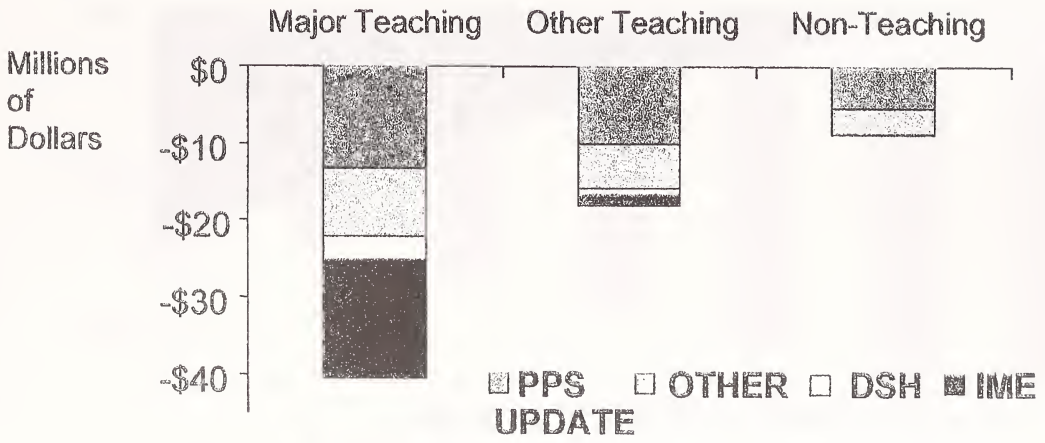
Short -Term General, Non-Federal Hospitals, 1997

	Major Teaching Hospitals As a % Of All Hospitals
Hospitals	6%
Admissions	21%
Outpatient Visits	22%
Emergency Visits	17%
Neonatal ICU	40%
Pediatric ICU	53%
Burn Units	70%
Indigent Care	44%

SOURCE: AAMC analysis of AHA Annual Survey of Hospitals, 1997 data.
NOTE: Major Teaching Hospitals are 277 members of the Council of Teaching Hospitals and Health Systems (COTH).

Major Teaching Hospitals Shoulder Greater Burden of BBA Cuts

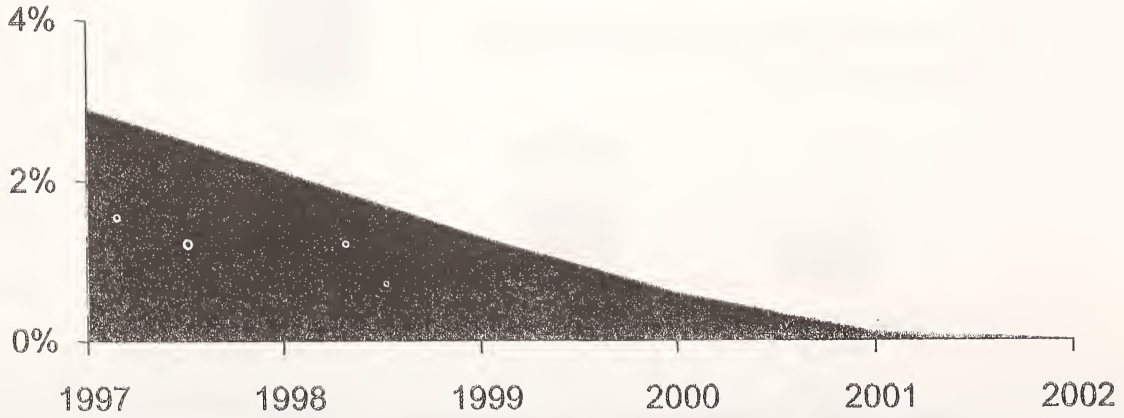
Median Cumulative Dollar Losses, 1998-2002



SOURCE: PPS XIV Medicare Cost Report Minimum Dataset.
NOTE: Difference between projected payments under "status quo" and "BBA" scenarios.
OTHER includes Capital and Outpatient payment reductions.
Major teaching hospitals are hospitals with IRB ratios greater than or equal to 0.25, other teaching hospitals are those with IRB ratios less than 0.25, non-teaching hospitals are those without residents.

Average Major Teaching Hospital Margin Projected to Disappear

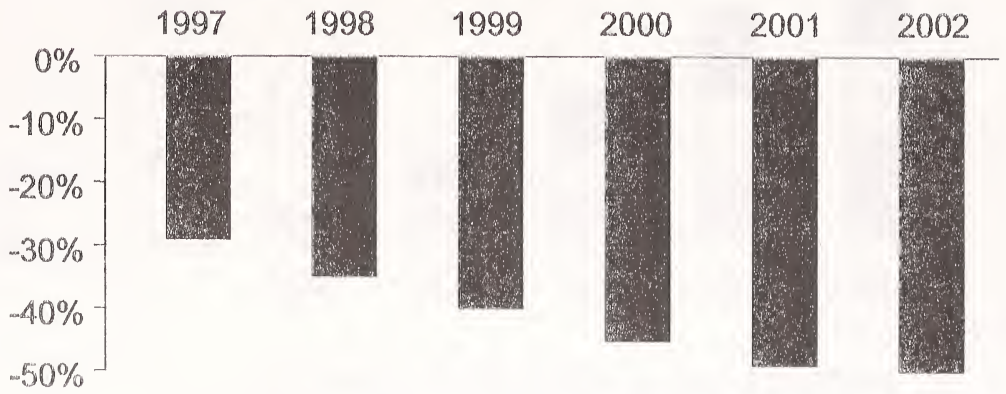
Median Projected Total Margin



SOURCE: PPS XIV Medicare Cost Report Minimum Dataset.
NOTE: Medians of trimmed data. Excludes Maryland, rural, SCH and hospitals with fewer than 90 beds.
Total margins include total hospital revenues and expenses.
BBA impact includes PPS, IME, DSH, capital, transfers and outpatient payment reductions.
Does not include estimate of teaching payments for Medicare Managed Care enrollees.
Major teaching hospitals are hospitals with IRB ratios greater than or equal to 0.25.

Nearly Half of Major Teaching Hospitals Projected to Lose Money

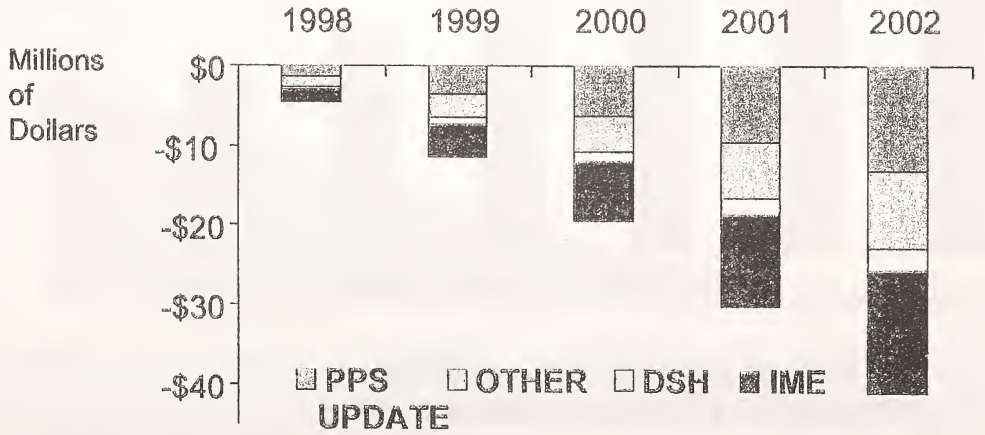
Percent of Major Teaching Hospitals with Negative Projected Total Margins



SOURCE: PPS XIV Medicare Cost Report Minimum Dataset.
NOTE: Medians of trimmed data. Excludes Maryland, rural, SCH and hospitals with fewer than 90 beds.
Total margins include total hospital revenues and expenses.
BBA impact includes PPS, IME, DSH, Capital and Outpatient payment reductions.
Does not include estimate of teaching payments for Medicare Managed Care enrollees.
Major teaching hospitals are hospitals with IRB ratios greater than or equal to 0.25.

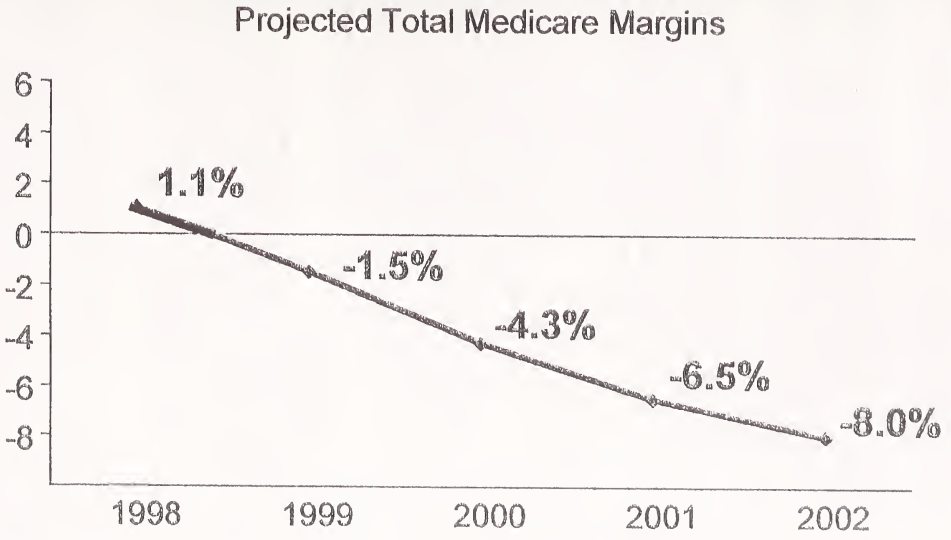
BBA IME Cuts Nearly Double Impact for Major Teaching Hospitals

Median Cumulative Dollars
(Expected Loss per Major Teaching Hospital)



SOURCE: PPS XIV Medicare Cost Report Minimum Dataset.
NOTE: Difference between projected payments under "status quo" and "BBA" scenarios. Chart shows cumulative financial difference.
OTHER includes Capital and Outpatient payment reductions.
Major teaching hospitals are hospitals with IRB ratios greater than or equal to 0.25.

Teaching Hospitals' Medicare Margins Projected to Decline Sharply



Source: The Lewin Group, May, 1999

Statement of Association of Community Cancer Centers, Rockville, MD

NEW STUDIES SHOW ALL HOSPITAL OUTPATIENT CANCER PROGRAMS WILL FACE LOSSES OF 32 TO 51 PERCENT UNDER APCS—APC METHODOLOGY CAUSES PERVERSE INCENTIVES TO USE OLDER DRUGS

ROCKVILLE, MD—Two new studies released by the Association of Community Cancer Centers (ACCC) demonstrate that university and community hospital cancer programs will encounter huge losses under the Health Care Financing Administration's (HCFA) proposed Ambulatory Payment Classifications (APC) system. The studies show that if APCs were enacted as proposed, the loss to hospital cancer programs would be $202 million in 1998, or 51 percent of the actual cost of chemotherapy and supportive care drugs.

The studies performed by The Lewin Group, ELM Services, Inc., and ACCC simulated the HCFA database that was used by the agency to produce the APC categories, then tracked the drugs in the database to see how reimbursement changed between 1996 (the year that HCFA used as its base year for calculations) and 1998 (the most recent year for which actual sales data to hospitals was available). A paper co-authored by members of the Lewin team and ACCC concludes that "the APC system will not work for oncology drugs and rapid innovations." The authors noted that keeping oncology under APCs would "threaten the quality of cancer care available to Medicare beneficiaries."

The studies also showed that the implementation of the Balanced Budget Act (BBA) would harm outpatient radiation oncology at U.S. hospitals, where 65 percent of all radiation oncology is currently conducted. Because of the structure of the formula-driven overpayment (FDO) implementation, radiation oncology is now reimbursed at $197 million below its Medicare-allowed costs, a 32.7 percent loss.

Outpatient cancer care services are delivered in community and university hospitals throughout the U.S. Community hospital-based cancer programs and centers treat 85 percent of all U.S. cancer patients. The top ten cancer centers see roughly 5 percent of all cancer patients, while other university cancer centers see another 10 percent. The authors note, "In the real world of hospital decision making, the inability to be directly compensated for this expensive group of drugs could quickly label the oncology area as a 'loser.'"

"The combined impact of losses for chemotherapy, supportive care drugs, radiation oncology, and chemotherapy administration is sufficient for many hospital administrators to question whether they can afford to suffer these levels of losses," said Dr. Lee E. Mortenson, ACCC's executive director and lead author on the paper. "APCs as proposed will mean that most university cancer centers will close their outpatient areas, many, if not all tertiary care community facilities will close, and many rural hospital cancer clinics will close. The implications are vast for both treatment and cancer research."

APC Methodology Causes Perverse Incentives to Use Older Drugs

The study notes that because the APC methodology lumps inexpensive drugs in with expensive drugs, "older drugs are overcompensated and newer drugs, presumably more costly yet more effective, are undercompensated." The APCs put all chemotherapy drugs into four categories and reimburse them for an average cost of their 1996 values. This practice leads to some older drugs receiving compensation at 1,500 percent of their price, while most drugs approved since 1995 are compensated at just 58 percent of their cost.

The Lewin-ACCC analysis notes that, "These wide variations imply that HCFA's APC categories are not cost homogeneous and likely do not reflect comparable clinical meaning." The authors go on to conclude that, "the economic incentives are strong and unbalanced. Payment systems should be incentive neutral across clinical options, and this is clearly not the case. This lack of balance can lead to perverse outcomes."

The analysis points out that while the four APC buckets HCFA devised for chemotherapeutic drugs were relatively balanced in 1996, by 1998 they are significantly unbalanced, causing hospitals to be reimbursed far below costs. This rapid change is central to the problem since older and less costly drugs saw utilization increase by 41 percent, while newer drugs, which were financial "losers," increased in use by 311 percent. One ACCC study shows that innovation in oncology drug use is extremely high: More than 40 new drugs have been introduced since 1992. These drugs have more than 220 new indications as documented in the peer-reviewed lit-

erature and/or by the two national reference compendia, which Congress requires Medicare and Medicaid to use for reimbursement of patient care.

APC Methods Miss Supportive Care Drugs And Will Always Lag Behind

To simplify its analysis, HCFA eliminated all bills with more than one procedure, lowering its original sample size to one-quarter of all 1996 claims. In oncology, however, this methodology had several perverse effects. Most oncology drug and radiation oncology treatments are given as a series and billed the same way, as a "batch." In addition, most chemotherapy regimens are multi-drug regimens that have been found to be more effective than single drug regimens for many forms of the disease. But in this case, HCFA's methodology leads to the number of cancer claims being reduced to only one-eighth of their original size. HCFA edits, which eliminated all claims with units of more than 50, reduced the sample size to just 6 percent. The authors note that, "Most likely the bills remaining after excluding multiple procedure claims would be error correction bills, or an occasional drug not given as part of the more common multi-drug chemotherapeutic combinations."

Loss of the multiple procedure drugs might also explain the disappearance of another significant portion of cancer drug payments. HCFA could find just $2.8 million in supportive care drug payments for all Medicare patients in 1996! Because this number was insignificant, HCFA chose to "bundle-in" or not reimburse supportive care drugs.

Using information from IMS Health, a national research firm that tracks direct sales to hospitals and hospital outpatient departments, the ACCC team was able to calculate that Medicare patients actually received $89 million in supportive care drugs in 1996. HCFA found just 3 percent of that number. Given the size of the missing pool of supportive care drug reimbursement, the researchers conclude, "that the majority of supportive care cost claims were unaccounted for in the payment calculations because of the elimination of bills with multiple procedures."

The authors also note that "since HCFA by necessity must continue to use data that are several years old to develop its APC relative prices, HCFA's approach to drug reimbursement will continually lag far behind the innovation curve."

Researchers Conclude APCs Cannot Manage Innovation

The authors note that APCs are unlike Diagnosis Related Groups (DRGs), the successful hospital inpatient prospective payment system. That system gives hospitals "a payment for a clinically cohesive set of treatments that affect a patient with a specific diagnosis." While the authors note that DRGs give hospitals "wide latitude" and have encouraged the use of new treatment approaches, especially if these lowered other costs, they find that the APC system does not provide this latitude and is likely only "to encourage the use of low-cost care."

The researchers conclude, "Unlike the DRG system, the OPPS (outpatient prospective payment system) has little room for altering the pattern of care by using a high cost technology that lowers the overall cost of care. If the HCFA database cannot be altered to capture appropriate information, such as supportive care drugs, and if its methodologies cannot be altered to accommodate the wide variability of drug pricing, efficacy and use, there will be significant problems going forward for oncology drug delivery and other high technology areas."

Stating that recalculation of the existing APC payment system is not a workable solution given the 300 new drugs in the current research pipeline and other rapid innovations in oncology, the authors note that "HCFA's data will always lag behind reality in significant ways." In the meantime, they suggest, "Congress may have to take action to assure that Medicare patients receive adequate care in hospital outpatient settings. Certainly in a time of budget surpluses, this is no time to cut benefits to Medicare patients in critical areas such as oncology."

ACCC institutional and group practice members include more than 575 medical centers, hospitals, oncology practices, and cancer programs. This group of institutions now sees almost 40 percent of all new cancer patients seen in the U.S. each year.

The Association provides a national forum for addressing issues that affect community cancer programs, such as regulatory and legislative issues, measurements of the quality of care, and clinical research. Its unique membership includes all members of the cancer care team: medical and radiation oncologists, surgeons, cancer program administrators and medical directors, oncology nurses, radiation therapists, oncology social workers, and cancer program data managers.

Statement of Center for Patient Advocacy, McLean, VA

The Center for Patient Advocacy is pleased to submit written testimony to the Subcommittee on Health as it examines changes made to the Medicare program by the Balanced Budget Act of 1997 (BBA). We commend the Subcommittee for conducting this hearing and for its commitment to ensuring that our nation's seniors continue to have access to the quality health care the Medicare program was created to deliver.

Founded in 1995, the Center for Patient Advocacy is a private, non-profit, grassroots organization representing the interests of patients nationwide and dedicated to ensuring that patients have timely access to quality health care. With a grassroots coalition of more than 60,000 "citizen lobbyists" across the country, the Center has brought the patient's perspective to several critical issues that have come before Congress in recent years, including managed care reform, FDA modernization and biomaterials reform. We have also launched a new division of the Center this year, the Access to Cancer Care Alliance (ACCA), which is actively addressing access and quality care issues for cancer patients. In all of our endeavors, our goal has been and continues to be to ensure that health care policymakers recognize the needs and concerns of patients and work to address them.

As you know, the BBA made significant changes to the Medicare program, some of which may have unintended consequences. Of particular concern to the Center and ACCA is the Health Care Financing Administration's (HCFA) proposed rule to implement a prospective payment system (PPS) for hospital outpatient departments. We are very alarmed that, if implemented in its current form, the rule would severely limit patient access to needed cancer treatments and threaten the continued research and development of state-of-the-art cancer drugs and therapies.

Under the current Medicare payment system, hospital outpatient departments are reimbursed for their services on a cost basis, providing physicians the ability to select the treatments they believe will most benefit their patients. This helps to ensure that cancer patients, more than half of whom are enrolled in the Medicare program, will receive the latest, most effective treatments. However, if HCFA's rule is finalized, this will no longer be the case.

HCFA has proposed to lump all cancer treatments, including chemotherapy and radiation, into a small number of Ambulatory Payment Classifications (APCs), bundling the costs of drugs, biologics and supportive care services into a single payment. Such a payment system will create incentives for hospitals and health care providers to place financial considerations above the medical needs of cancer patients. In fact, the Medicare Payment Advisory Commission (MedPAC) raised this very concern in its June 1998 report to Congress stating that "payment systems for ambulatory services should not engender financial incentives that could inappropriately influence clinical decisionmaking." However, this is exactly what the APC regulation would do.

Due to the vast differences in the cost of certain cancer treatments and the reimbursement levels HCFA has proposed, patients inevitably will be denied access to many cancer treatments. This is especially of concern when it comes to the latest advancements in cancer care, which usually are more expensive. Under HCFA's proposal, treatments introduced later than 1996 are reimbursed at the lowest level—less than $60.00. As a result, outpatient centers will be forced to either stop providing cancer treatments, or incur significant financial losses for providing such care. Moreover, incentives would be created that would encourage providers to select only older, less effective cancer treatments for their patients. The impact on patients, particularly those is rural areas, is devastating, as patients would no longer have ready access to needed state-of-the-art treatments.

Also of significant concern is the issue of supportive care drugs. Supportive care drugs are used as part of comprehensive cancer treatment with the majority of patients with cancer and help them tolerate and survive their treatment. Without supportive care drugs, optimal cancer care is severely compromised. However, it appears that HCFA does not believe the use of supportive care drugs is common and therefore has proposed not to provide specific payments for them. Instead, the costs of supportive care drugs are "bundled" into the overall APC payment. As a result, patients will either be forced to endure cancer treatments without the benefit of needed supportive care services, or be denied access to cancer treatments altogether.

Finally we are concerned that HCFA's APC proposal poses a significant threat to cancer care research and development. As new technologies increasingly become unavailable due to inadequate reimbursement, research and development could be dis-

couraged or delayed, denying the patients of today and those of future generations access to more effective treatments.

The Center for Patient Advocacy and our Access to Cancer Care Alliance believe that in order to preserve patient access to needed cancer services, including chemotherapy, radiation and supportive care drugs, such cancer services should be excluded from the proposed payment system. And we strongly support the Medicare Full Access to Cancer Treatment Act (H.R. 1090), legislation introduced by Congressman Gene Green (D–TX), that would provide a "carve-out" for cancer care under the PPS.

It is our understanding that one option being explored to address this issue is a limited carve-out, excluding the 10 free-standing NCI designated cancer centers from the outpatient PPS. While we certainly agree that such a provision would benefit some cancer patients, much more needs to be done. The 10 NCI designated centers represent only a small percentage, approximately 5%, of cancer patients affected by the outpatient PPS. Therefore, such a limited carve-out would not adequately address the underlying problems facing the 95% of cancer patients who would continue to be subjected to significant restrictions on their ability to access quality cancer care.

The Center for Patient Advocacy agrees with Members of Congress that the Medicare program needs to be reformed to ensure that it will continue to benefit the nation's seniors as we move into the 21st century. But, we do not believe that HCFA should provide financial incentives that encourage providers and hospitals not to deliver quality patient care. This is especially troubling when we talk about Medicare patients who represent more than half of all cancer diagnoses and more than 60% of all cancer deaths. And if we are to continue our efforts to find a cure and develop new treatments for cancer, it is critical that patients have access to the latest treatments the medical community has to offer.

While the Center continues to work with HCFA, Members of Congress and other advocacy organizations to address this issue, we strongly believe that a legislative fix is needed to guarantee that Medicare patients with cancer will continue to have access to the quality care the Medicare program was created to help deliver.

On behalf of cancer patients and their families nationwide, we appreciate your consideration of our concerns and look forward to working with the Subcommittee on this very important issue.

Statement of Social HMO Demonstration Sites: Elderplan, Brooklyn, NY, SCAN, Long Beach, CA, Sierra Health Services/Health Plan of Nevada, Las Vegas, NV

Elderplan, SCAN and Sierra Health Services/Health Plan of Nevada are Social HMO demonstration sites located in Brooklyn, NY, Long Beach, CA and Las Vegas, NV, respectively. We appreciate the opportunity to submit written testimony for this hearing focusing on refinements to the Balanced Budget Act of 1997 (BBA).

The Social HMO demonstration originally was established under the Deficit Reduction Act of 1984 to test innovative models for integrating acute and long-term care services for Medicare beneficiaries. The demonstration was expanded to include several additional "second generation" sites under the Omnibus Budget Reconciliation Act of 1990. Waiver authority for the first generation Social HMO sites was extended in 1987 and 1990 and authority for first and second-generation sites was extended in 1993 and 1997 by Congress. Waiver authority currently is scheduled to expire December 31, 2000. The Social HMO demonstration emerged out of a recognition that the supportive care required by the frail elderly and disabled is not adequately covered by Medicare or Medicaid, leaving the burden of such care to fall most often on family members. In contrast to acute conditions, which can be effectively treated in clinic or inpatient hospital settings, chronic illnesses and severe disabilities require a "systems" approach to care. A central role of the Social HMO model—and one that distinguishes it from traditional M+C plans—is to provide and coordinate additional services as an extension of benefits covered by Medicare and Medicaid. These services go beyond the type of supplemental benefits often offered by traditional M+C plans and include prescription drugs, eyeglasses, hearing aids, dentures, foot care, mental health, nutritional services, care management and a wide range of home and community-based services. Coverage of additional chronic care services enables many frail elderly to live safely in their own homes and avoid or delay nursing home placement. Importantly, these additional services are provided in a budget neutral fashion; i.e., at a cost no greater than the equivalent of

what Medicare would have paid for like beneficiaries receiving services under the original Medicare program.

Elderplan, SCAN and Sierra seek the subcommittee's consideration of technical amendments to the Balanced Budget Act of 1997 (BBA) to extend our current legislative authority and to implement the recommendations made by MedPAC regarding M+C risk adjusted payments for the frail elderly. Below is a brief description and rationale for our proposed amendments. More detailed documentation is included in Attachment A.

Extension of Social HMO Waiver Authority

The BBA extended Social HMO waiver authority through December 31, 2000. It also directed the Secretary to:

- submit to Congress, by not later than January 1, 1999, a plan for the integration of health plans offered by social health maintenance organizations (including Social HMO I and II sites) and similar plans as an option under the Medicare+Choice program;
- include in the plan a transition for social health maintenance organizations operating under demonstration project authority;
- include in the plan recommendations on appropriate payment levels for plans offered by such organizations, including an analysis of the application of risk adjustment factors appropriate to the population served by such organizations.

HCFA has been unable to meet the specified timetable for submitting recommendations on permanency legislation. We understand that HCFA's Report is unlikely to be submitted to Congress before March 2000. Therefore, we seek Congressional support for a technical amendment to the BBA to extend our waiver authority until such time as Congress acts on legislation to make the Social HMO demonstration a permanent benefit option under the M+C program. Since the delay in HCFA's recommendations on permanency will prevent Congress from acting on legislation prior to 2000, a technical amendment extending our waiver authority is needed to prevent disruption of services to the approximately 80,000 beneficiaries served by Social HMOs until our program is made permanent. Keeping in mind that Social HMO waiver authority expires at the end of 2000, there are several reasons to take action this year:

1. Since Congress appears poised to act on BBA refinements in 1999, the enactment of additional BBA amendments (including an extension of Social HMO waiver authority) during an election year could be difficult to achieve.

2. Since it probably is unrealistic for Congress to enact major Medicare reforms during an election year, Social HMO permanency legislation is unlikely to be enacted before 2001.

3. Since the Social HMOs are required to begin phasing down operations and notifying beneficiaries of the potential for closure at the end of the first quarter of the year in which waiver authority expires, if Congress does wait until 2000 to act on an extension, such legislation would need to be enacted by March 31, 2000.

4. The Social HMOs and several other Medicare demonstrations have been exempted from the M+C risk adjustment through December 31, 2000 while HCFA explores risk adjustment methods more appropriate to the frail elderly population. It is clear that HCFA will not have established an alternative payment structure for the frail elderly by early next year, however, to provide guidance to Congress on the payment provisions of permanency legislation for the Social HMOs. A delay in the development of an alternative to the current M+C risk adjustment methodology could further delay enactment of permanency legislation.

5. Social HMOs, like other health plans, must submit to HCFA their ACR filing and proposed benefit packages by July 1 of the year prior to benefit offering. Absent an extension of waiver authority, the Social HMOs would be required to submit this data to HCFA without assurance of operating authority for 2001 and based on the assumption that the Social HMO payment structure would remain unchanged.

HCFA has informed Congressional staff that the agency has the authority to extend the Social HMO waiver authority and, therefore, that Congress does not need to extend the waivers through statute. The Social HMOs are aware of HCFA's position on this matter but feel strongly that Congress extend our waiver authority through statute. First generation sites have never received an administrative waiver and have relied on Congress to extend our demonstration authority four times since our inception. While the BBA required HCFA to Report to Congress with a plan on how to integrate the Social HMOs into the M+C program as a standard benefit option, HCFA's focus appears to be on whether to make the Social HMOs a permanent benefit option. Further, while the States of Florida and Maryland both received planning grants to develop second generation Social HMO programs for the dually

eligible in 1998, in recent months, HCFA has reminded these states repeatedly that the Social HMO waiver authority expires at the end of 2000. This suggests that HCFA has doubts about the ability to implement these demonstrations as proposed by Maryland and Florida. Given the uncertainty of HCFA's approach toward Social HMO permanency, the Social HMO sites would feel more confident of our ability to survive the transition from demonstration status to permanency through an extension in law.

Alternative M+C Risk Adjustment for Frail Elderly

The Social HMOs urge the Subcommittee's serious consideration of MedPAC's recommendations to Congress on Medicare payment for the frail elderly, with some modifications. Attachment A lists several of MedPAC's recommendations, with our proposed changes and rationale for such changes. In general, MedPAC recommends that the Secretary study factors affecting the costs of care for the frail elderly to determine the need for an alternative to the current risk adjustment methodology. We strongly support the need for an alternative risk adjustment mechanism. Like several other Medicare demonstrations cited in MedPAC's report, the Social HMOs have been paid under a risk adjustment mechanism that accounts for the impact of functional impairments on medical costs for the frail elderly. Payment research regarding the frail elderly population shows that functional impairment status is among the most significant indicators of higher risk and costs. For example, several studies show that Medicare costs for frail elderly who are deemed nursing home certifiable, but who are receiving care in the community, are over three times higher than average Medicare per capita costs.

While HCFA has begun to explore alternatives to the standard risk adjustment methodology, we understand that it has some concerns about the continued use of certain mechanisms in establishing payment rates for frail elderly programs such as the use of self-report health status measures as a risk identification tool and the use of functional impairment measures as part of a risk adjustment methodology. We understand that the basis for concern relates to administrative issues such as data collection. The Social HMOs and other demonstration programs have been collecting functional data for upwards of fifteen years through a combination of self-report health status tools that identify high-risk candidates, follow-up clinical assessments for those identified as high risk, and third party verification of assessments. Accordingly, we believe it would be inappropriate to discard these risk adjustment strategies. These and other issues are addressed by MedPAC's recommendations.

Enrollment Levels

The Omnibus Reconciliation Act of 1990 codified minimum enrollment levels for the Social HMO demonstrations, providing that sites could enroll "not less than" 12,000 beneficiaries per site. This level was increased to 36,000 under the BBA. While the statutory language defines this enrollment threshold as a floor, HCFA began interpreting this threshold as a ceiling beginning in 1998. According to HCFA, an increase in enrollment beyond 36,000 "would not be prudent until HCFA determines how it will risk adjustment payments and how Social HMOs will transition into the M+C environment." Treating the enrollment threshold as an upper limit instead of a floor has created enormous problems for several of the Social HMOs that are at or close to the limits. The Health Plan of Nevada (HPN) has reached it's enrollment limit and has been forced to wait list beneficiaries who wish who join the Social HMO. Since HPN has a standard M+C contract, it can enroll new members under their standard plan on an interim basis. Notwithstanding this advantage, however, the administrative process of wait listing is enormously burdensome to both the beneficiary and the plan. SCAN is within a few thousand members of reaching the limit and has been forced to substantially scale back marketing efforts. Last year, as SCAN began to approach the enrollment threshold, the company had to lay off half of its sales staff to slow enrollment growth. Since SCAN does not have a standard M+C contract, wait listing may not be a viable option since beneficiaries are likely to simply join another plan. Elderplan has received approval at the state level for expansion into three additional counties (Manhattan, Queens and Staten Island) that will substantially increase the potential pool of beneficiaries. The enrollment cap could begin to hinder Elderplan's expansion prior to the enactment of permanency legislation as well. Like SCAN, Elderplan does not have standard M+C contract as a fall back position.

Elderplan, SCAN and Sierra request the Subcommittee's consideration of an increase in the enrollment threshold to help maintain plan viability until permanency legislation is enacted. While the enrollment cap of 36,000 assumed a transition to

permanency by the end of 2000, the delay in HCFA's report to Congress until sometime next year will almost certainly delay permanency until 2001 at the earliest. It will be difficult for these plans to survive until permanency without relief from the enrollment cap. The enrollment cap makes it extremely difficult to offer competitive contracts to employees and providers and creates an environment of uncertainty for prospective enrollees. Providers are reluctant to contract with plans that provide limited access to clients while imposing special requirements relative to the terms and conditions of the demonstration. Opportunities for professional growth, advancement and compensation for employees also are limited for plans that are prevented from growing. SCAN lost several key employees last year when their enrollment growth was put on hold. Since the BBA scoring in 1997 assumed enrollment of 36,000 at 9 demonstration sites, or a total of up to 324,000 enrollees, an increase in the enrollment threshold during the transition period should be cost neutral. There are currently only 4 Social HMOs operational and the earliest the Florida and Maryland sites could begin enrolling would be late in 2000 or early 2001.

* * * * *

We appreciate the Subcommittee's serious consideration of the attached amendments as part of a larger package of refinements to the BBA.

Social HMO Proposed Medicare Amendments 1999

SUMMARY

Enact a technical amendment to Medicare to extend Social HMO demonstration authority until such time as Congress enacts legislation making the Social HMOs a permanent benefit option under M+C coordinated care plan options.

Consistent with MedPAC's June Report to Congress, and with modifications proposed by the Social HMOs, direct the Secretary to examine and develop appropriate payment methodologies for health plans serving frail Medicare beneficiaries, as follows:

Direct the Secretary to study factors affecting the costs of care for frail Medicare beneficiaries and develop an alternative risk adjustment methodology for M+C plans serving this population that includes functional impairment factors by January 1, 2001.

Postpone application of the current M+C risk adjustment methodology to specialized plans until an appropriate payment methodology is established.

In the long term, the Secretary should set capitation payments for traditional Medicare benefits for frail beneficiaries based on their characteristics, not on the type of plan to which they belong.

Performance measures for programs for frail Medicare beneficiaries should reflect their health care needs, special practices of care, and the value of additional benefits provided under demonstration authority.

Special measures for evaluating and monitoring care for frail Medicare beneficiaries should be included in the M+C plan quality measures and reporting requirements.

Medicare demonstrations should have the option of maintaining continuous open enrollment or complying with standard M+C enrollment rules.

Enact a technical amendment to Medicare to extend Social HMO demonstration authority until such times as Congress enacts legislation making the Social HMOs a permanent benefit option under M+C coordinated care plan options.

Rationale: The BBA extended the Social HMO waiver authority through December 31, 2000. It directed the Secretary to report to Congress by January 1, 1999 regarding a plan for integrating the Social HMO demonstration into the M+C demonstration into the M+C program as a permanent benefit option. HCFA currently anticipates completing its Report to Congress by the end of 1999. Had the report arrived on time, Congress would have had two full years to consider permanency legislation in the year waiver authority expires, which is an election year with a shortened legislative calendar. Further, an important component of the permanency legislation includes recommendations on an appropriate payment methodology. Given that HCFA is unlikely to have developed an alternative to the interim M+C risk adjustment methodology for the frail elderly by early 2000, Congress would be forced to develop permanency legislation without guidance from HCFA regarding an appropriate payment mechanism. An extension would protect Social HMO bene-

ficiaries from disruption in services (or being forced to disenroll and find new coverage), provide HCFA the time needed to explore alternative risk adjustments, and give Congress time to evaluate options for permanency legislation.

Modifications to MedPAC Recommendations on Managed Care for Frail Medicare Beneficiaries: Payment Methods and Program Standards

MEDPAC RECOMMENDATIONS 5A:

The Secretary should study factors affecting the costs of care of frail beneficiaries and all other Medicare beneficiaries to determine if changes are needed to improve Medicare+Choice risk adjustment system.

Proposed Modifications:

The Secretary should study factors affecting the costs of care for frail beneficiaries and all other Medicare beneficiaries including, but not limited to functional and cognitive impairments.

The Secretary should develop a risk adjustment methodology the incorporates functional status factors, building upon the M+C claims-based risk adjustment, by January 1, 2001.

This study should identify data needed to support improvements in the M+C risk adjustment system, including, but not limited to self-reported health status surveys, assessments of client health, functional and cognitive status and utilization data including such services as high risk screening, care management, home and community-based services and special interventions that may not be specified in the Medicare Part A and B benefit package.

Rationale: Research conducted by the Long-Term Care Data Institute and others shows that the PIP and HCC risk adjustment methodologies dramatically underpay plans for frail beneficiaries with functional impairments due, in part, to the absence of functional impairment factors. The PIP methodology would result in underpayments of up to approximately 40% for nursing home certifiable enrollees living in the community. Therefore, Congress should direct HCFA to include, at a minimum, risk factors related to functional status factor in whatever alternative payment model it devises. Additionally, early indications from HCFA staff suggest that it is interested in identifying alternative frailty factors due to the costs of collecting functional data across the Medicare population and concerns with the validity of current data collection instruments. Since the Social HMOs and other Medicare demonstrations have been collecting this type of data successfully for upwards of 15 years, we do not believe the functional factors should be eliminated. Further, we are concerned about the potential impact of an alternative risk adjustment based on utilization factors such as home health care, given the dramatic cuts in Medicare fee-for-service payments under the BBA.

MEDPAC RECOMMENDATIONS 5C:

The Secretary should postpone by at least one year the application of the interim Medicare+Choice risk adjustment system to specialized plans. Plans should be paid using existing payment methods until a risk adjustment or other payment system is developed that adequately pays for care for frail Medicare beneficiaries.

Proposed Modifications:

The Secretary should postpone ~~by at least one year~~ the application of the interim Medicare+Choice risk adjustment system to specialized plans. *Specialized* plans should be paid using *Their* existing payment methods until a risk adjustment or other payment system is developed that adequately pays for care for frail Medicare beneficiaries. *"Specialized plans" shall include the Social HMO, PACE, EverCare, and Minnesota Senior Health Options demonstrations and dual eligible demonstrations operating under waiver authority granted by HCFA prior to or subsequent to the enactment of this provision.*

Rationale:

The inclusion of a one year exemption from the current M+C payment methodology assumes that an alternative methodology will be available within this timeframe. The period of the exemption for specialized plans should be linked to the availability of a new, more appropriate payment methodology to avoid the need for future legislative extension of the exemption.

MEDPAC RECOMMENDATIONS 5E:

Performance measures for programs for frail Medicare beneficiaries should reflect the beneficiaries' health care needs and special practices for their care.

Performance measures for programs for frail Medicare beneficiaries should reflect the beneficiaries' health care needs, ~~and~~ special practices for their care, *and the value of additional benefits provided under Social HMO demonstration authority.*

Rationale:

The Social HMOs believe that it would be helpful to assess the benefits of additional services provided to beneficiaries under demonstration programs, such as the long-term care benefits provided by the Social HMOs.

MEDPAC RECOMMENDATIONS 5F:

The Secretary should include special measures for evaluating and monitoring care for frail Medicare beneficiaries in the Medicare+Choice plan quality measurement and reporting requirements.

Proposed Modifications: None.

MEDPAC RECOMMENDATIONS 5G:

The Secretary should not now limit enrollment into the Program of All-Inclusive Care for the Elderly to a particular time of the year.

Proposed Modifications:

The Secretary should not now limit enrollment into the Program of all-Inclusive Care for the Elderly *or other specialized plans for frail elderly operating under Medicare demonstration authority,* to a particular time of the year. Medicare demonstrations should have the option of maintaining continuous open enrollment or complying with standard M+C enrollment rules.

Rationale:

The Social HMOs Believe that all of the Medicare demonstrations serving frail elderly should be accorded the benefit of greater flexibility in enrollment, due to the smaller size of our risk pools resulting from enrollment caps, and the need to maintain minimum enrollment to effectively manage risk. We also believe that continuous open enrollment should be permitted on a voluntary basis, since the larger Social HMOs the have standard M+C contracts in addition to Social HMO contracts may wish to employ a single approach to enrollment across all plans.

Statement of Stanley N. Lapidus, President, Exact Laboratories, Inc., Maynard, MA

Chairman Thomas, Congressman Stark, and Subcommittee members, I appreciate the opportunity to discuss the issue of refinements to the Balanced Budget Act (BBA) as they affect small biotechnology companies, like Exact Laboratories, which are working to develop cutting-edge life-saving technologies.

The bottom line of my message is simple: The BBA wisely added important preventive screening benefits to Medicare, including screening for colorectal cancer. But because these technologies are specifically spelled out in the law, they may limit opportunity for new and improved technologies.

But before I discuss the BBA further, let me first introduce you to the challenges of colorectal cancer and the innovative technology Exact Laboratories has developed in the fight against colorectal cancer.

Colorectal cancer is the second leading cause of death from cancer in the United States. It appears frequently among both men and women of all races and is commonly seen in individuals sixty-five and older. Colorectal cancer is particularly deadly among African American men, who have approximately a 45 percent increased mortality rate in comparison to other groups.

Colorectal cancer develops slowly from a pre-cancerous lesion commonly known as a "polyp." It is curable if it is identified at its earliest stages when it can be completely removed, sometimes only with very minor surgery. Therefore, until there's a cure, the key to reducing mortality from colorectal cancer is early detection.

There are currently three types of screening tests for colorectal cancer, each of which is mentioned in the BBA. The most common method, the stool blood test, only finds cancers and polyps if they bleed, which is not the case for most early cancers and polyps. A second test involves the examination of the left side of the colon by passing a flexible tube (flexible sigmoidoscope) from the anus through the rectum for a distance of about two feet. This allows the medical professional to directly see and remove or biopsy any suspicious areas. Doctors recommend a fecal blood test annually and the flexible sigmoidoscopy every five years for individuals with a family history of colorectal cancer or who are over the age of fifty.

A third test can examine the entire colon by use of a special x-ray called a double contrast barium enema, which requires that the colon be completely emptied of stool. Because African Americans have a greater tendency to develop cancer on the right side of the colon, out of reach of the flexible sigmoidoscope, this test is more helpful for that constituency and was added to the recommended tests listed in the BBA through the good work of many of you on the committee and your colleagues who have a particular interest in this issue.

A colonoscopy—which examines the entire colon using a longer scope than that used in the flexible sigmoidoscopy—is generally used only for individuals who have a high risk of developing colon cancer, although there has recently been some interest among professionals in using this as a screening test every ten years.

All of these screening methods have their drawbacks. The stool blood test isn't very accurate; and I probably don't need to tell many of you on the panel that the flexible sigmoidoscopy, the double contrast barium enema, and the colonoscopy involve a great deal of discomfort and inconvenience. It therefore shouldn't come as a surprise that there are many compliance problems with each of these tests. And that means early detection doesn't happen as frequently as it should—in fact, we estimate that more than 75% of the at-risk population (those age 50 and above) is non-compliant.

We at Exact Laboratories believe we can change that problem.

We are a small company based in Massachusetts dedicated to playing a leading role in the eradication of colorectal cancer through the development of an innovative, patient-friendly method for detecting early stage colorectal cancer and its precursor lesions. Under our system, the patient only needs to provide a stool sample through non-offensive collection and transport containers we have developed. The sample is then processed and examined by our labs for DNA from any abnormalities which indicate a development of colorectal cancer. Let me be clear: Because the DNA we examine is from the tumor or precancerous lesion itself, this is not a so-called "gene test" to detect susceptibility to developing colon cancer.

Our clinical tests at the Mayo Clinic thus far indicate a very high level of accuracy: Exact testing has found 90 percent of the cancers; 73 percent of the polyps, and no false positive results. We will soon embark on further, broader clinical trials.

Because our test is extremely patient-friendly, we believe compliance will increase. And, as compliance increases, the incidence of mortality from colon cancer will decrease. It is worth repeating: Early detection saves lives.

Mr. Chairman and distinguished Members of the Subcommittee, as I mentioned at the beginning of my testimony, Congress has wisely recognized the life-saving and cost-cutting benefits of screening for cancer by including coverage of these tests under the BBA. However, the current language in the BBA encompasses only the current tests described above and "such other tests or procedures, and modifications to tests and procedures under this subsection, with such frequency and payment limits, as the Secretary deems appropriate, in consultation with appropriate organizations." Although this language does not preclude new technologies from consideration, we believe it places unnecessary hurdles before a small company with great promise like Exact Labs.

We believe the current language of the BBA can be vastly improved by recognizing new technologies, and would recommend that Congress consider amending the BBA by changing the language to something similar to that found in HR 1816, the Eliminate Colorectal Cancer Act of 1999. That language requires that private health insurance plans "shall cover the method and frequency of colorectal cancer screening deemed appropriate by a health care provider treating such participant or beneficiary, in consultation with the participant or beneficiary." In doing so, Congress will be accommodating the advent of new screening technology and returning the decision of what method of screening to where it belongs—the doctor, in consultation with the patient.

Thank you once again, Mr. Chairman and Members of the Subcommittee, for the opportunity to speak to you today.

Statement of Home Health Services & Staffing Association

Thank you Chairman Thomas and members of the Subcommittee for holding this important hearing today to review the impact of the Balanced Budget Act of 1997 (BBA 97) on Medicare patients and providers. The hearing is extremely timely as Congress determines the legislative changes needed this year for Medicare providers.

The Home Health Services & Staffing Association (HHSSA) is a non-profit association representing over 1,500 free-standing, proprietary home health companies in 48 states. The Association is primarily interested in ensuring a sound prospective payment system (PPS) is implemented on October 1, 2000. Recognizing that the interim payment system (IPS) is extremely flawed, and meant to be the reimbursement policy for a short period, we would strongly urge Congress to focus the debate on the prospective payment system being developed by the Health Care Financing Administration (HCFA). A proposed rule on the new system is scheduled for October of this year, and a final rule is to be announced in July 2000. At the end of this testimony, HHSSA has provided recommendations that will contribute to the success of a cost-effective, Medicare home health benefit for the growing aging population in the United States.

George Washington University Announces Findings on Impact of BBA 97

On September 14, George Washington University announced the findings of its study on the impact of BBA 97 on home health patients and providers. (An Examination of Medicare Home Health Services: A Descriptive Study of the Effects of the Balanced Budget Act Interim Payment System on Access to and Quality of Care, Center for Health Services Research & Policy, George Washington University, September 1999) The study describes the status of the home health industry after patients and providers were under IPS for one full year. This differs in comparison to the studies conducted by the General Accounting Office (GAO) and the Medicare Payment Advisory Commission (MedPAC), which were completed before all home health agencies were on IPS a full year.

Many of the findings of the George Washington University study are similar to the findings of GAO and MedPAC. For example, access to home health services for the sickest, most frail Medicare beneficiaries has been gravely impacted by the implementation of BBA 97, even though the eligibility for these services was not changed. The study also highlights other problems that need to be considered as the Medicare home health benefit moves to a PPS next year.

Some of the significant findings were:

1. Access to home health services for the sickest patients is being eliminated. Home health agencies of all auspices are being compelled by IPS to radically alter their case mixes by eliminating the most costly patients. Diagnoses being the most severely affected are diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), and mental or emotional disorders. See Report at 20–21.

2. Access to specialty care is being eliminated even for the beneficiaries who are still able to obtain services. Clinical staffing levels have declined 37% since 1994 with the greatest reductions being in specialty therapists and home health aides. See Report at 24–25.

3. Access to medically necessary services is likely to deteriorate further because many agencies are subsidizing Medicare services with charitable and private funds, and HCFA has yet to implement the "proration" requirement in BBA 97. See Report at 25–26.

4. An additional reduction in reimbursement by 15%, as is scheduled for October 1, 2000, will exacerbate these already severe access problems. See Report at 36.

5. Any PPS based on data generated under the interim payment system is likely to be flawed and will exclude the sicker patient population. See Report at 36.

These findings come on the heels of HCFA's recent projection that, in fiscal year 2000, 93.5% of home health agencies participating in Medicare will have their cost reimbursement limited by either the per visit or the per beneficiary limit. (64 Fed. Reg. at 42780, August 5, 1999) This means that in the coming fiscal year nearly 95% of home health agencies will be reimbursed at less than their actual costs even before the additional 15% cut.

STATISTICS/DATA CONFIRM GEORGE WASHINGTON UNIVERSITY STUDY

The findings of the study are reflected in the dramatic changes in the home health industry. The following list is not complete, but highlights the problems associated with the implementation of BBA 97 on Medicare home health services. This means that home health is not able to be a vital component to the health care delivery system at a time when it could be a cost-effective service for the growing elderly population.

1. According to HCFA's most recent utilization data for home health, the total number of claims received in fiscal year 1997 was 20,959,349 and the total number of claims received in fiscal year 1998 was 16,880,856—about a 20% decrease in the number of claims received. (HCFA Contractor Reporting of Workload Data, February 1, 1999)

2. 2,195 Medicare-certified home health agency offices have closed since January 1998, according to a survey of state health licensure departments. Hardest hit was Texas, where 352 agencies and another 438 branch offices closed. Other states with large numbers of closures: Louisiana–250, California–153, Florida–97, Missouri–91, Oklahoma–87, Tennessee–67, and Indiana–60. (Eli's Home Care Week, Volume VIII, Number 6, February 8, 1999)

3. Home care stocks dropped 43.8% in 1998 according to an annual survey by Hilton Head, South Carolina-based HealthCare Markets Group, Inc. (Eli's Home Care Week, Volume VIII, Number 2, January 11, 1999)

4. Home care stocks dropped 55.8% between April 1, 1998 and March 31, 1999 according to a financial analysis of home care public companies by Houlihan, Lokey, Howard & Zukin Investment Bankers. (March 31, 1999)

5. Home Health Corporation of America filed for Chapter 11 bankruptcy protection on February 18, citing Medicare cutbacks as one cause of its mounting debt. HHCA will not go out of business, but will downsize by releasing 300, or about 10% of its employees. (HomeCare Monday, February 22, 1999)

6. Employment at free-standing home health agencies declined by 7,000 jobs in January 1999. Since September 1997, free-standing HHAs have lost 61,000, or 8.5%, according to the Bureau of Labor Statistics. (Eli's Home Care Week, Volume VIII, Number 7, February 15, 1999)

7. In Home Health Inc. reported a loss of $132,000 on revenue of $18.6 million in the quarter ended December 31. That compares with net income of $186,000 on revenue of $27.9 million during the same period the year before. (. . . home health line, February 15, 1999)

8. Home care workers received only a .7% wage increase in 1997, while Americans as a whole saw a 3.4% increase, according to new Labor Department statistics. (*The Washington Times*, Eli's Home Care Week, Volume VIII, Number 6, February 8, 1999)

9. A Visiting Nurses Association branch in Illinois found that Medicare payments are now so low that it made the painful decision to abandon 25 patients who needed the most expensive care, rather than face the possibility of having to go out of business in a few months and strand some 300 patients. (The *Washington Post*, A1, May 10, 1999)

10. Medicaid is picking up the slack for Medicare caused by the BBA, Christine Ferguson, director of Rhode Island's Human Services Department testified at a May 12 Senate Finance Committee hearing on Medicare reform. "There has been a widespread decrease in access to home care services," and increased hospitalizations have resulted, she said. (*Eli's Home Care Week*, Volume VIII, May 24, 1999)

11. By 2002, hospital-based HHAs will have seen a payment reduction of over $5.5 billion—a 22% cut from pre-Balanced Budget Act levels, says a new study by the Lewin Group. (*Eli's Home Care Week*, Volume VIII, May 24, 1999)

12. The Congressional Budget Office (CBO) projected the Medicare savings from the home health benefit to be $16.1 billion over five years. The CBO revised baseline in March 1999, showed a 300% higher savings than projected at $48.8 billion over five years. The rate of growth for home health services was significantly lower in 1998 than any other health care provider. (Congressional Budget Office, Revised Baseline Calculations on BBA 97, March 1999)

Recommendations

HHSSA strongly urges Congress to review the Medicare home health benefit under the context of the new reimbursement system to be implemented on October 1, 2000. The Health Care Financing Administration (HCFA) is developing a PPS for home health and the proposed rule should be announced this month. As the aging population increases, HHSSA requests that Congress determine the role home

health services should play and ensure that the proper reimbursement matches that role.

As the home health industry moves to a PPS, we urge congressional consideration of the following:

• Development of the Prospective Payment System (PPS):

Please note that a new, untested PPS will go into effect for all home health agencies on October 1, 2000, without any phase-in. The PPS rates will be reduced by a mandatory 15% cut at the same time.

HHSSA urges Congress to ensure the home health PPS: 1) encompasses all eligible Medicare beneficiaries in an adequate reimbursement structure, 2) is simple for agencies and HCFA to administer, and 3) is easily monitored for quality of care delivered to the Medicare beneficiaries.

If HCFA is unable to provide an adequate PPS, HHSSA would urge Congress to consider a model similar to the proposal introduced by Senator Connie Mack (S. 1414), which is based on data from a Kaiser Family Foundation study.

• Elimination of the 15% Cut Scheduled on October 1, 2000:

HHSSA urges Congress to act this session to eliminate the 15% cut scheduled for implementation—regardless of whether PPS is implemented—on October 1, 2000.

According to Congressional Budget Office projections, home health services will save the Medicare program 300% more than was projected at the time BBA 97 was passed. This decline can also be seen in the plummeting rate of growth for home health services and the significant decrease in claims submitted to the Medicare fiscal intermediaries.

Any additional reductions will further increase the problems eligible Medicare beneficiaries are having gaining access to the home health benefit.

• Enact an Outlier Provision for the Sickest, Most Frail Medicare Beneficiaries:

IPS severed the sickest, most frail Medicare beneficiaries from the Medicare home health benefit. Although these beneficiaries are still eligible to receive Medicare home health services, home health agencies no longer have the capacity to care for these patients.

As observed in the George Washington University study, access to care for many patients has been jeopardized. Patients with conditions such as complex diabetes, MS, COPD and heart failure are having difficulty obtaining home health services.

In order to reinstate the reimbursement for these patients, HHSSA urges Congress to support an outlier that may be used in the short term under IPS and can also be used under PPS.

An important aspect to remember is that HCFA's PPS is being developed with post-BBA 97 data. The data obtained after the implementation of IPS is flawed because it does not include the sickest patients who are no longer receiving services. HHSSA urges Congress to ensure that proper data is used in the development of PPS.

• Require HCFA to Provide Home Health Agencies an Extended Repayment Schedule of Up to Five Years Interest-Free for IPS-Related Overpayments:

BBA 97 was implemented on October 1, 1997. Many home health agencies were not informed of their per-beneficiary limit until long after they had been under the new reimbursement system. There was little opportunity for the fiscal intermediaries to provide agencies with their aggregate per-beneficiary limit.

Several HHSSA members were under IPS for over a year before HCFA provided them with their actual per-beneficiary limit. This made budgeting difficult for agencies that did not know their limit in advance.

At the end of 1998 and beginning of 1999, home health agencies began receiving notices of "overpayments" from HCFA. Many agencies had overwhelming amounts of money to be recouped from the federal government. In order to assist agencies with large overpayments, HHSSA urges Congress to support a five-year interest-free repayment plan. This is particularly important as the industry is moving to a completely new reimbursement system on October 1, 2000, and serious cash flow problems related to the change in reimbursement could occur.

HHSSA would like to thank the Subcommittee on Health for your efforts in providing relief for home health patients and providers. If you should need further information or would like a complete copy of the George Washington University study, please contact us at (202) 296–3800.

[An attachment is being retained in the Committee files.]

Statement of House Rural Health Care Coalition

As members of the House Rural Health Care Coalition, we appreciate the opportunity to address the Subcommittee regarding our concerns for the future of health care in rural America. The Balanced Budget Act (BBA) has led to many unintended consequences for health care in rural areas, while the Health Care Financing Administration's interpretation of the BBA has exacerbated many of these problems. As a result, numerous rural health care providers are teetering on the brink of reducing and eliminating essential services, and a vast number of citizens face the threat of being shut out from receiving vital health care.

The House Rural Health Care Coalition urges you to include the rural specific provisions included in our bill, H.R. 1344—the Triple-A Rural Health Improvement Act, in any Medicare reform proposals brought before the U.S. Congress, large or small. Introduced on March 25, 1999, this bill is designed to protect the rural health infrastructure, provide targeted BBA relief, improve access to Medicare health plan options, increase availability of telemedicine, and create common sense rural health tax policy.

A summary of the provisions included in H.R. 1344 is attached. In particular, we would like to highlight the following key issues which are vital to ensuring access to health care services for rural Medicare and Medicaid beneficiaries:

(1) *Hospital Outpatient Prospective Payment System*—We support exempting rural hospitals from the outpatient prospective payment system (PPS). The outpatient PPS is intended to cut the fat out of Medicare payments. Rural hospitals have always done more with less and have no fat to cut. Maintaining the PPS for rural hospitals will prove devastating to the rural health infrastructure. The outpatient PPS provision in H.R. 1344 directs HCFA to establish a methodology that guarantees health care services will continue to be available to beneficiaries in rural and frontier communities. This is accomplished by exempting Critical Access Hospitals, Medicare Dependent Hospitals, and Sole Community Hospitals from the outpatient PPS.

(2) *Hospital Transfer Penalty*—We support repealing the hospital transfer penalty, a provision included in the BBA that requires hospitals to return a portion of the DRG payment if a patient is transferred to another care setting before the DRG payment period has expired. The transfer penalty disproportionately affects efficient rural providers because average lengths of stay for patients in rural hospitals are shorter than average lengths of stay in other hospitals. H.R. 1344 repeals the hospital transfer penalty that is imposed on hospitals that transfer patients to other care settings before the DRG payment period has expired.

(3) *Critical Access Hospitals*—Critical Access Hospitals (CAH) were established under the BBA to allow rural hospitals to convert to a limited service hospital status. These hospitals are given relief from certain Medicare regulations and are paid based on cost. Under the BBA, a closed or downsized hospital does not qualify for the program. H.R. 1344 allows a hospital that has closed in the past five years to qualify for the CAH program. It also permits CAHs to be granted deemed status in order to gain accreditation by the Joint Commission of Healthcare Organizations. In addition, the bill allows any CAH to choose the all-inclusive rate payment option for its facilities and physician services. This reimbursement system was used by the Rural Primary Care Hospital program which was the demonstration project testing the feasibility of the CAH concept. Changing the reimbursement system has impacted the way CAHs contract with doctors and made the conversion to CAHs less appealing.

(4) *Medicare Dependent Small Rural Hospitals*—Medicare Dependent Hospitals (MDHs) are hospitals in rural areas with 100 beds or fewer whose patient load is 60% Medicare beneficiaries. The following changes contained in H.R. 1344 will allow this program to benefit more rural hospitals. It (a) changes the base year for eligibility to the most recent hospital fiscal year ending in 1998; (b) lowers the Medicare patient load from 60% to 50% in order to qualify for the program; and (c) includes a hold harmless for the MDH rebasing so that any hospital which would lose this status from changes would be allowed to keep it.

(5) *Rural Impact Statements*—We support establishing a mechanism to ensure that rural concerns are taken into account in federal health policy making. H.R. 1344 mandates that any legislative or regulatory proposal to change a federal program must contain a rural impact statement that—at a minimum—includes an impact analysis on: (a) rural safety net providers; (b) rural primary care providers; (c) rural hospitals; (d) federally-qualified health clinics and rural health clinics; (e) local rural economies; and (f) where rural residents would be affected.

In closing, we respectfully request that the Subcommittee consider these important rural specific provisions, as well as the other important provisions in H.R. 1344, in the context of any BBA relief legislation to be brought before Congress. Thank you for the opportunity to bring these important concerns that impact the health and well-being of residents living in rural America before you today.

Sincerely,

The Honorable Jim Nussle, Co-Chair
The Honorable Mike McIntyre, Co-Chair
The Honorable Doug Bereuter, Steering Committee Member
The Honorable Marion Berry, Steering Committee Member
The Honorable Henry Bonilla, Steering Committee Member
The Honorable Larry Combest, Steering Committee Member
The Honorable Peter DeFazio, Steering Committee Member
The Honorable Jo Ann Emerson, Steering Committee Member
The Honorable Rick Hill, Steering Committee Member
The Honorable Ron Kind, Steering Committee Member
The Honorable David Minge, Steering Committee Member
The Honorable Jerry Moran, Steering Committee Member
The Honorable James Oberstar, Steering Committee Member
The Honorable John Peterson, Steering Committee Member
The Honorable Earl Pomeroy, Steering Committee Member
The Honorable Charles Stenholm, Steering Committee Member
The Honorable Bart Stupak, Steering Committee Member
The Honorable Mac Thornberry, Steering Committee Member

Summary of the Triple-A Rural Health Improvement Act (H.R. 1344) Introduced by Congressmen Jim Nussle and Mike McIntyre

PROTECTING THE RURAL HEALTH INFRASTRUCTURE

Hospital Outpatient Prospective Payment System—Many hospitals in rural areas will be faced with extreme financial difficulties due to the new outpatient PPS. This provision of the bill directs HCFA to establish a methodology that guarantees health care services will continue to be available to beneficiaries in rural and frontier communities. This is accomplished by exempting Critical Access Hospitals, Medicare Dependent Hospitals and Sole Community Hospitals from the outpatient PPS system.

Hospital Transfer Penalty—The Balanced Budget Act included a provision that requires hospitals to return a portion of the DRG payment if a patient is transferred to another care setting before the DRG payment period has expired. This provision has already created significant financial challenges for many rural hospitals. This provision repeals the hospital transfer penalty that is imposed on hospitals that transfer patients to other care settings before the DRG payment period has expired.

Sole Community Hospital (SCH) payment update—These hospitals are considered the only source of inpatient services that are reasonably available within a geographic area. Many SCHs are effectively losing money because the Medicare reimbursement for these types of hospitals has not been updated to keep up with economic factors. This provision would update the base cost-reporting period from 1982 to the most recent audit year. This provision was included in the Senate-passed BBA, but dropped in conference.

Critical Access Hospitals—Critical Access Hospitals (CAHs) were established under the BBA to allow rural hospitals to convert to a limited service hospital status. These hospitals are given relief from certain Medicare regulations and are paid based on cost. Under the BBA, a closed or downsized hospital does not qualify for the program.

This provision allows a hospital that has closed in the past 5 years to qualify for the CAH program. Additionally the provision allows Medicaid to reimburse CAHs for services provided to Medicaid recipients. Finally, the provision allows CAHs to be granted deemed status to allow them to be accredited by the Joint Commission on Accreditation of Healthcare Organizations.

A second provision will allow any CAH to choose the all inclusive rate payment option for their facilities and physician services. This reimbursement system was used by the Rural Primary Care Hospital program which was the demonstration project testing the feasibility of the CAH concept. Changing the reimbursement system has impacted that way CAHS contract with doctors, and made the conversion to CAHs less appealing.

Medicare Dependent Small Rural Hospitals—Medicare Dependent Hospitals are hospitals in rural areas with 100 beds or fewer whose patient load is 60% Medicare beneficiaries. The following changes contained in the bill will allow this program to benefit more rural hospitals. (1) The bill changes the base year for eligibility to the most recent hospital fiscal year ending in 1998. (2) The bill lowers the Medicare patient load from 60% to 50% in order to qualify for the program. Finally, there is a hold harmless for the Medicare Dependent Hospital rebasing so that any hospital which would lose MDH status from changes would be allowed to keep it.

DSH Reclassification—This provision permanently extends the ability of hospitals to apply to the Medicare Geographic Classification Review Board for DSH payment reclassification. The provision also requires HCFA to develop new criteria for DSH applications by 1/1/2001.

Medicare Wage Index—The Medicare Wage Index is a portion of the PPS payment formula. Hospitals that meet certain criteria can apply to have their wage index reclassified to a higher-paying geographic area. These provisions make it easier for rural hospitals to apply for wage index reclassification for the purposes of higher payment.

The provisions also include a Sense of the Congress that the current Hospital Wage Index should only be used for Hospital inpatient PPS systems, and not applied to other Medicare payments.

Medicare Wage Index and Geographic Reclassification—Under current law, hospitals are allowed to apply to the Medicare Geographic Classification Review Board to be geographically reclassified for higher inpatient payment rates. This provision deems that all hospitals that are geographically reclassified for the purposes of inpatient service wage index should be deemed reclassified for other services which are geographically adjusted using a wage index. (E.g., SNF, home health). (Never included for the summary for distribution).

Graduate Medical Education—These provisions make technical changes to the Balanced Budget Act. The BBA limits the number of medical residents for which a hospital may be reimbursed to the number of residents on staff on 12/31/96. This ignores the many residents who spend time training outside a hospital, in rural health clinics, and who may have been approved for training, but not yet started their program by that date. The bill recalculates the cap to include the number of residents that may not have been in the hospital-proper and those that had been appointed, but had not yet started their training on the cut-off date.

Medicare Fee Schedule—Under this provision, physician assistants, nurse practitioners, and clinical nurse specialists in underserved rural areas will be reimbursed with direct reimbursement at 100% of the fee schedule for similar services provided by primary care physicians.

Coverage of Mental Health Services—This bill requires Medicare to reimburse services provided in a health professional shortage area by any state-licensed mental health practitioner. Currently, only certain professions can be reimbursed.

Medicare Waivers for Providers in Rural Areas—This provision requires HCFA to establish a waiver mechanism that recognizes any counties defined as rural based on census tract data as rural for the purposes of Medicare reimbursements for hospitals and providers.

Ambulance Restocking—This provision allows hospitals to restock ambulances with medical products used while treating patients without being in violation of the Stark anti-kickback law.

Medicaid Reimbursement for FQHCs and RHCs—This provision repeals the phase-out of cost-based reimbursement by Medicaid for federally qualified health clinics and rural health clinics.

Medicaid Reimbursement for Physicians' Assistants and Nurse Practitioners—This provision requires Medicaid to include Physicians' Assistants and Nurse Practitioners as covered providers.

Access to Data—This provision requires the National Health Service Corps, Centers for Disease Control, and Census Bureau to negotiate inter-agency agreements with agencies and offices within the Department of Health and Human Services in order to provide access to agencies' data for research purposes.

Improving Access to Medicare Health Plan Options

Medicare + Choice payment/AAPCC Reform—The AAPCC formula is how Medicare managed care payment rates are determined. These rates are determined on a county-by-county basis. The BBA made a number of changes to this formula in order to give higher payment rates to managed care plans in rural areas. However, the new formula has not been fully funded due to smaller than anticipated spending increases and the budget neutrality provision of the program. This provision elimi-

nates the budget neutrality provision so that the blended rate will be fully funded and go into effect.

Medicare Cost-Contracts—Medicare cost-contracts are a type of managed care in which HCFA reimburses cost-contractors on their costs as long as the costs meet HCFA standards of reasonableness. Cost-contractors are required to accept all Part B beneficiaries. The Balanced Budget Act eliminates Medicare cost-contracts in 2003. These plans are overwhelmingly located in rural areas, and are the only type of managed care plans available in many rural areas. Due to the slowness of many managed care companies to enter the rural market, it is likely that the ban on the cost-contracting will result in the elimination of managed care as an option for many rural residents. This provision exempts all current cost-contractors from the sunset provision and allows them to continue to offer cost-contracts after 2003.

Medicare + Choice Rural Demonstration Project—Directs the Secretary to establish to promote the establishment and monitor the viability of provider sponsored organizations and other rural based managed care entities serving Medicare beneficiaries in rural and frontier areas.

Advancing Special Rural Concerns

Rural Impact Statements—This provision mandates that any legislative or regulatory proposal to change a federal program must contain a rural impact statement that, at a minimum, includes an impact analysis on: (a) rural safety net providers; (b) rural primary care providers; (c) rural hospitals; (d) federally qualified health clinics and rural health clinics; (e) local rural economies; and (f) where rural residents would be affected.

Health Professional Shortage Area Recruitment—Current law states that communities cannot receive federal recruitment assistance until they lose a provider. This provision allows pending retirements or resignations to be considered when a community applies for assistance.

Underserved Area Designation by the Office of Personnel Management—OPM designates underserved areas by state for the purposes of reimbursement under the FEHBP. This provision requires OPM to use HHS's designation criteria for underserved areas and designate underserved areas on a county-by-county basis, not a state-by-state basis.

Shortage Designations—This provision requires the Bureau of Primary Care to withdraw its proposed revision of the methodology for determining Health Professional Shortage Areas and Medically Underserved Areas. This definition would be detrimental to rural areas. Instead the Bureau will be required to initiate a negotiated rule-making process to develop a new methodology that more appropriately recognizes medically underserved and health professional shortage areas in rural, frontier and urban areas.

Establishment of an Office of Inactive Reserve for the Public Health Service Corps—Currently, there is no office to coordinate the call-up and deployment of inactive members of the PHSC reserve corps. This provision is a sense of the Congress that the Department of Health and Human Services should establish such an office. This is endorsed by the Public Service Corps.

Increasing Availability of Telemedicine Services

The legislation makes a number of changes to way that Telemedicine services are currently regulated and reimbursed.

(1) Permits any currently covered Medicare service to be reimbursed. This includes coverage for all types of appropriate telemedicine interactions between patients and providers who are qualified to bill for similar types of in-person services. This provision would also authorize payment for store and forward telemedicine services in addition to the in-person presentation of services.

(2) The legislation states that the referring physician need not be present at the time of the telehealth service, and that any health care practitioner can present the patient.

(3) Requires HCFA to establish a telemedicine payment methodology that pays professional fees to both providers, and includes a technical fee to the facilities to cover the cost. Additionally, HCFA is required to establish a separate Medicare billing code for telemedicine in order to monitor the utilization of health services.

(4) Requires HCFA to establish patient protection rules governing the assessment of the telemedicine copay. Specifically, HCFA must ensure that patients are informed of the co-pay in advance of the teleconsult and that patients must actually receive medical treatment or advice during the consult.

(5) Availability of telemedicine reimbursement is expanded from only health professional shortage areas to all rural areas.

(6) The legislation requires the Secretary of Health and Human Services to issue initial and subsequent reports on efforts to ease cross-state licensure barriers that may arise through the use of telemedicine services.

(7) The legislation authorizes the development and administration of a grant/loan program for telemedicine activities in rural areas. It also authorizes appropriations for the program.

(8) The legislation formally authorizes an existing group of Cabinet level and private sector members. This group is to focus on identifying, monitoring, and coordinating federal telehealth projects. The group will report each year to Congress.

CREATING COMMON SENSE RURAL HEALTH TAX POLICY

100% tax-free scholarships for National Health Service Corps—The National Health Service Corps provides scholarships to individuals who commit to providing health care in underserved areas. Historically, these scholarships have been tax-free. However the IRS has recently begun taxing the scholarship as income. These scholarships should be returned to their tax-free status in order to prevent the undermining of the program.

Emergency Medical Services Prevention Act—Many EMS units, especially in rural areas, do not have adequate funds to maintain infrastructure. This provision allows EMS units to issue tax exempt bonds for revenue purposes.

Bank Deductibility—this provision increases access to tax exempt financing for small not-for-profit health care facilities through the States' Health and Education Facilities Authorities. There is a $5 million borrowing cap.

MAYO FOUNDATION
ROCHESTER, MINNESOTA
Septembet 24, 1999

The Honorable Gil Gutnecht
U.S. House of Representatiaves
Washington, DC 20515–2301

Dear Representative Gutnecht:

The Balanced Budget Act of 1997 was a landmark piece of legislation that appears to have helped move the federal budget from a pattern of chronic deficit to one of significant surplus. However, there is mounting evidence that the Medicare payment reductions included in the Balanced Budget Act are significantly greater than estimated at the time of its passage, and the reductions are causing major financial hardship for many health care providers. Congress is now considering legislation that may give some partial relief from the effects of BBA, and Mayo Foundation strongly supports this effort. As the legislative process moves forward, we want to set out our priorities for congressional consideration.

The effects of the Balanced Budget Act have been extreme, and some of the major payments cuts are yet to be implemented. We estimate that the five-year cumulative impact on Mayo Foundation will be a reduction of $411.5 million. The largest portion of the reduction is a $177 million reduction in funding for graduate medical education. As a major integrated healthcare delivery system, we have also felt the effects of virtually every category of payment reduction: hospital, physician, home health, skilled nursing, clinical lab, and others.

While we believe many of these payments need to be corrected, we believe the greatest threat to the overall integrity of the health care system, and to Mayo Foundation, is the major reduction in the indirect medical education (IME) payments to teaching hospitals. There is sound evidence that the infrastructure of many of America' premier medical centers is already being significantly threatened by the IME reduction, and the full effect is yet to be felt. The IME reduction is phasing in over four years, and we are only in year two. Therefore, we strongly urge you to support, at a minimum, halting the IME reduction at the 1999 level. We believe that IME payments are a critical element in supporting the education and research missions of Mayo and other academic health centers.

We also would like to reiterate our position that the long run viability of Medicare requires more than these BBA "fixes." The Medicare program needs fundamental restructuring. We have communicated to you in the past our position that Medicare should be based on patient choice, competition, and innovation.

We support changing Medicare to a model similar to the Federal Employees Health Benefits Plan. Without such fundamental restructuring, the future will be

a never ending succession of attempts to keep a flawed model afloat through bureaucratic micromanagement and price controls, thus undermining the viability of the entire health care system.

Thank you for your efforts, and we look forward to working with you to create a better Medicare program.

Sincerely yours,

MICHAEL B. WOOD, M.D.

Statement of Medical Device Manufacturers Association

The Medical Device Manufacturers Association (MDMA) appreciates this opportunity to submit comments for the record of the subcommittee's October 1 hearing on Medicare Balanced Budget Act refinements. MDMA is a national trade association based in Washington, D.C. that represents nearly 130 independent manufacturers of medical devices, diagnostic products and health care information systems. As the national voice for the innovators and entrepreneurs in the medical device industry, MDMA seeks to improve the quality of patient care by encouraging the development of new medical technology and fostering the availability of beneficial innovative products.

MDMA would like to highlight briefly two important refinements for your subcommittee to consider as you develop legislation to refine the Balanced Budget Act of 1997 (BBA).

PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENTS

MDMA has a number of concerns with the Medicare prospective payment system (PPS) for hospital outpatient departments set forth by the BBA. We believe the Health Care Financing Administration's (HCFA's) proposal for creating the outpatient PPS would hinder the introduction and adoption of new medical technologies in the Medicare program. Health professionals should not be prevented from using the latest technologies on Medicare patients simply because Medicare's payment system cannot keep pace with medical innovation.

To refine the outpatient PPS and to help Medicare keep up with technological advances, MDMA is a proud supporter of S. 1626, the Medicare Patient Access to Technology Act of 1999, introduced by Sen. Orrin Hatch and a bipartisan group of his colleagues. In addition to reforming Medicare's systems for coding and paying for medical technologies, S. 1626 would improve the outpatient PPS in three major ways:

- by restructuring the proposed classification system to create groups of procedures that are more similar in cost and more closely related clinically;
- by establishing a transition period for new technologies that will allow for the development of adequate outpatient cost data to ensure appropriate reimbursement; and
- by developing a process for updating classifications and payments annually to ensure appropriate utilization and reimbursement of the most appropriate services.

MDMA encourages this subcommittee to include similar provisions in its package of BBA refinements.

INHERENT REASONABLENESS

MDMA believes that HCFA is attempting to evade the due-process requirements established in the BBA in cutting Medicare reimbursement levels for durable medical equipment.

Section 4316 of the BBA gives the Health Care Financing Administration (HCFA) the authority to increase or decrease grossly deficient or excessive Medicare payments for durable medical equipment and other home health equipment. However, the BBA placed limits on HCFA's use of this so-called "inherent reasonableness" authority. Specifically, the BBA prohibits HCFA from reducing or increasing payments during any year by more than 15 percent without due process for suppliers of such equipment.

However, HCFA proposed August 13 to use its "inherent reasonableness" authority to cut Medicare reimbursement for several categories of durable medical equipment by nearly 50 percent over the next few years. To MDMA, this action violates the intent and the spirit of the BBA.

In our opinion, HCFA is clearly evading the law by phasing in these massive cuts over two- to five-year periods without giving suppliers their due-process rights as

specifically provided by the BBA. While MDMA supports HCFA's efforts to purchase prudently, we believe HCFA must be fair to all parties and follow the intent of Congress in doing so.

To remedy this situation, MDMA is asking Congress to prohibit HCFA from increasing or decreasing Medicare reimbursement for durable medical equipment by more than 15 percent in any five-year period without due process. MDMA is also requesting Congress to prevent HCFA from implementing such a change more than once in any five-year period.

These changes will provide medical technology manufacturers and Medicare beneficiaries with adequate protection from capricious and drastic payment cuts that jeopardize patient access to quality medical products. These changes would not prevent HCFA from imposing major reimbursement cuts, but would clarify the intent of Congress that HCFA provide due process to medical technology manufacturers and other stakeholders before such cuts are made.

Thank you for this opportunity to bring these two issues to the subcommittee's attention as you develop a legislative plan to refine the BBA.

Statement of National Association for Home Care

Introduction

Thank you for the opportunity to submit testimony for the record on issues relating to the impact of the Balanced Budget Act on the Medicare home health benefit. The National Association for Home Care (NAHC) is the largest national home health trade association representing nearly 6000 member organizations. Among our members are Medicare-participating home care providers, including non-profit providers like the visiting nurse associations, for-profit chains, hospital-based providers and freestanding providers. We also represent home care aide and hospice organizations.

NAHC is deeply appreciative of the attention the Chairman and Members of the Subcommittee have shown regarding the problems created by the home health provisions of the Balanced Budget Act of 1997, P.L. 105–33 (BBA). NAHC offers these comments and recommendations as proposed refinements to the BBA home care provisions.

There are numerous refinements to BBA, and to the manner in which the Health Care Financing Administration (HCFA) is interpreting and implementing it, that the Committee could act upon which would provide significant relief to home care providers nationwide. Our recommendations are outlined below, and fall into four separate categories.

First, legislative modifications to the home health interim payment system that would provide much-needed relief for the failing home care program.

Second, clarification of Congressional intent and instruction to HCFA to correct faulty interpretations of some of the BBA home care provisions.

Third, implementation of technical changes to the BBA that would ease financial and operational burdens on home health providers with little or no costs associated; and

Fourth, implementation of general refinements to provide relief from financial and operational burdens imposed by HCFA-initiated regulatory requirements.

I. Legislative Initiatives

A. The most devastating change for home health providers under the BBA has been the enactment and implementation of IPS. The payment reductions under IPS, coupled with HCFA's stringent interpretations, have had severe repercussions for both providers and beneficiaries. The following data illustrate the dramatic changes that have occurred to the Medicare home health program since the passage of BBA.

- According to HCFA data from its OSCAR files, as of August 18, 1999, there have been 2486 home health agency closures, nearly 25% of all home health agencies in the United States. Under current policies, this trend shows no leveling off, and access to care continues to be seriously compromised.
- Approximately 550,000 fewer Medicare beneficiaries received home health services in 1998 than in 1996. The change represents a 15.2% reduction in number of patients served.
- Average home health agency reimbursement has decreased 29% since 1996.

• Medicare home health spending is now projected by the Congressional Budget Office (CBO) to be reduced by $48 billion over five years (FY 1998–2002), rather than the $16.1 billion initially projected at the time BBA was passed.
• In 1997, home health care represented only 9% of Medicare but was slated for about 14% of the FY 1998–2002 reductions in Medicare spending. Currently, the home health program comprises less than 7% of the Medicare program and is now projected to absorb 24% of the Medicare cuts between FY 1998–2002.

NAHC understands the need for Congress to make prudent decisions with respect to changes in the Medicare program. We also believe that the highest priority must be to target resources to ensure that beneficiary access is protected, and that the vital home care infrastructure be stabilized so that it is positioned to respond to future needs of the disabled and elderly. For this reason, we have put a high priority on legislative relief for the home health program that would:

• Eliminate the 15% additional cut scheduled for October 1, 2000;
• Target resources to an outlier provision for high-cost patients;
• Increase the IPS per-visit cost limit; and
• Provide relief from financially disabling overpayments.

1. Eliminate The 15% Payment Cut Scheduled For October 1, 2000

Under the BBA, expenditures under a PPS were to be equal to an amount that would be reimbursed if the cost limits and per beneficiary limits were reduced 15%. Even if PPS was not ready to be implemented on October 1, 1999, the Secretary of Health and Human Services was required to reduce the cost limits and per beneficiary limits in effect on September 30, 1999, by 15%. The Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESAA) delayed the 15% reduction for all home health agencies until October 1, 2000.

NAHC believes that the additional 15% cut to Medicare home health outlays on October 1, 2000, would close down a substantial percentage of home health agencies that have so far survived the IPS. HCFA's August 5 regulation on the FY 2000 home health cost limits estimates that 93.5% of surviving home health agencies will exceed their per-beneficiary cost limit or per-visit cost limit. In addition, HCFA conservatively estimates that the average agency will have to repay 12% of its Medicare reimbursement.

Home health providers—who have already experienced an average 29% reduction in reimbursement since the BBA '97 (even with the passage of OCESAA)—are struggling to keep costs under the per-visit and per-beneficiary cost limits and repay IPS-related overpayments. With an additional 15% cut, beneficiaries in many areas of the country would lose access to home health services, and for beneficiaries in many rural counties, this loss would be the loss of their local health care.

Congress included the additional 15% cut because CBO mistakenly projected it was needed to meet BBA savings goals; most recent CBO estimates that reductions in home care through 2002 will exceed BBA goals by $32 billion.

2. Target Resources For An Outlier Provision For High-Cost Patients

In their 1999 reports to Congress, the General Accounting Office and the Medicare Payment Advisory Commission confirm that the beneficiaries who are most costly to treat are at risk of losing access to home health care. While neither report concluded that access to home care has become a crisis, it must be noted that the reports are based, for the most part, on data from the first quarter of calendar year 1998, a time when many agencies had not yet transitioned to IPS, and no agencies had been notified of their per-beneficiary limits.

The IPS aggregate per-beneficiary limits, based on 1993–94 data, do not reflect the increased severity of most home health agencies' case-mix populations. Recent technological advances have expanded the scope of services provided to Medicare beneficiaries. Services such as parenteral and enteral nutrition, chemotherapy and ventilator care can now be provided in the home. These services require specialized nursing services as well as prolonged home visits, extensive case management, and discharge planning that add further to the cost per visit.

Through an outlier payment, additional resources can be targeted to those providers that care for the high cost patient. An expenditure limit on outlier payments would ensure fiscal soundness.

3. Increase The IPS Per Visit Limit

BBA reduced the per visit cost limits from 112% of the mean to 105% of the median per visit costs for freestanding agencies. IPS forces providers to reduce the total number of visits delivered by patients. However, as the number of visits decreases, costs per visit increases. Under the 1998 OCESAA, the per visit limits were raised from 105% to 106% of the median. This 1% increase was insufficient to help

providers who are operating under cost limits that have been reduced from 14–22% under BBA. The current cost limits are inadequate to cover the costs of providing care and to account for the increased administrative costs of participation in the Medicare program due to HCFA's regulatory initiatives. Agencies in rural areas and inner cities have been particularly hard hit by reductions. Their costs tend to exceed national averages because of longer travel times between visits and higher wages resulting from the lingering personnel shortages in rural areas, or the added costs of security escorts and language translators in the cities.

4. Provide Overpayment Relief

Nationwide home health agencies are being charged with Medicare overpayments related to IPS. These overpayments have resulted from delayed notifications to agencies of their reimbursement limits under IPS, and in faulty calculation of the limits by Medicare's fiscal intermediaries. Because the IPS payment reductions were so deep, and implemented so quickly, agencies had little time to adjust to the changes. Agencies continued to serve eligible patients, spending payments for care that were later deemed "overpayments." HCFA has not released nationwide statistics on overpayments, but one fiscal intermediary reports that for 1998, 84% of its $1 billion plus in overpayments are attributable to IPS. While the Administration has indicated it is providing three-year repayment plans to all agencies, with the first year interest free, this is not occurring. HCFA also has authority to establish "compromise" repayment amounts on overpayments due, but has refused to utilize this authority.

Congress should, at a minimum, direct HCFA to immediately issue clarifying standards for repayments that reflect the Administration's earlier commitment (three years, first year interest free). Further, Congress should consider legislation waiving interest on overpayments for three years. Congress should also direct HCFA to utilize overpayment compromise authority on an expedited basis in order to resolve inequities created through implementation of IPS.

II. Faulty Interpretations of BBA By HCFA

B. Congress should clarify its intent regarding certain BBA provisions that HCFA has interpreted wrongly or too restrictively. As these are administrative refinements, they should have no impact on budget scoring.

1. *Inflation Rate in Payment Limits.* HCFA went beyond the intent of Congress, further reducing the per beneficiary payment limits by about 6 percent, by excluding the inflation updates for 1995 and 1996 from its calculation of the limits. This "recapture" provision in BBA was intended to apply only to the per visit limits, but was improperly applied to the per beneficiary limits as well. There were no savings to "recapture" from the per beneficiary limit since it did not exist during 1995 and 1996.

Recommendation: Congress should direct HCFA to restore the 1995 and 1996 inflation updates for purposes of calculating the per beneficiary limits.

2. *Rate Calculation.* To establish IPS payment rates, BBA required HCFA to calculate on an agency by agency basis the average cost of services for each Medicare home health beneficiary during federal fiscal year 1994. However, HCFA failed to take into account that during 1994 there were patients who were served by more than one agency; therefore, the total number of beneficiaries for 1994 used to calculate the average annual cost per beneficiary was not an unduplicated count. As a result, the final average annual cost of services per patient was artificially lowered. It is estimated by Abt Associates that approximately 8 percent of all Medicare beneficiaries during the base period received care from more than one home health agency.

Recommendation: Congress should direct HCFA to recalculate the per beneficiary limits in a manner which reflects the true average annual cost per beneficiary for the base year by using an unduplicated beneficiary count.

3. *Exceptions Process for Per-Beneficiary Limit.* HCFA has refused to consider exceptions to the per beneficiary limits based on its narrow interpretation of the BBA which is silent on the issue of exceptions or exemptions to the cost limits. However, authorization for exceptions is found in existing law at Section 1861v(L)(ii) of the Social Security Act, 42 U.S.C. Sec. 1395x(v)(L)(ii). The amendment establishing the IPS is an amendment to existing law. The IPS amendment does not establish a wholly new provision; instead, it establishes a new clause, which modifies the general provision that Medicare reimbursement is subject to reasonable cost limits. Therefore, it is well within HCFA's regulatory authority to extend the process for requesting and granting exceptions to the cost limits to include per beneficiary limits.

Recommendation: Congress should direct HCFA to provide agencies the right to request exceptions to the per beneficiary limit.

III. Technical Changes to BBA

C. Congress should amend the BBA to ease burdens on home health agencies. These legislative changes would have little or no additional cost.

1. *Periodic Interim Payments.* Periodic interim payments (PIP) are issued to a small number of home health agencies so as to provide a steady cash flow for services rendered to Medicare beneficiaries. PIP has provided some measure of relief to home health agencies without large cash reserves to support delays in payments from HCFA. PIP has been particularly important to agencies during IPS, as significant problems have arisen with respect to determinations of per beneficiary and per visit limits. It is anticipated that cash flow difficulties will be even more pronounced with implementation of the forthcoming PPS. Home health costs, like hospital costs, tend to be front-loaded (the majority of costs are incurred early in the episode). Under a 60-day episodic payment cycle, agencies are likely to have expended most of the costs of providing care prior to receiving payment from HCFA. HCFA was forced to reinstate PIP for PPS demonstration agencies because they experienced such serious cash flow problems. Currently, PIP is set to expire on October 1, 2000.

Recommendation: Congress should enact legislation to maintain PIP. At a minimum, PIP should be extended for at least one year beyond implementation of home health PPS, to allow for a smoother transition to the new payment system.

2. *Consolidated Billing.* BBA required that, under PPS, payment for all services under the home health plan of care be reimbursed to the home health agency. This will require home health agencies caring for patients that are using home medical equipment to bill Medicare for the equipment and transmit the payment to the medical equipment supplier. Home health agencies would not be reimbursed any more than the rate allowed on the fee schedule for the equipment, but would be required to undertake considerable new responsibilities and liabilities. In addition, many beneficiaries will be seriously inconvenienced and deprived of agency choice in the process since they may be required to change suppliers. Requiring consolidated billing of home medical equipment results in no savings to the Medicare program.

Recommendation: Congress should repeal the consolidated billing requirement in BBA related to home medical equipment.

3. *15-Minute Visit Increment Billing.* BBA requires that home health agencies bill for care based on the number of visits provided and on the number of 15-minute increments per visit. However, agencies are only reimbursed based on the number of visits provided. The 15-minute increment information has no particular use under the current, cost-based system, nor under the forthcoming PPS. It is unclear what benefit collection of this 15-minute increment information will provide, since time in the home does not fully reflect the significant amounts of time agencies invest outside the home in caring for patients, including time spent communicating with physicians and family members, coordinating services with other home health personnel and community agencies, care planning, and clinical documentation. No evidence of a correlation between in-home time and quality of care has been established. However, billing of visits in 15-minute increments will require agencies to make significant systems changes and will impose substantial additional paperwork burdens on home care nurses and other staff. HCFA is implementing this requirement September 30, 1999.

Recommendation: Congress should repeal the 15-minute visit increment billing requirement.

4. *Proration.* BBA requires that the per beneficiary limit be prorated among agencies in cases where a patient received services from more than one agency in the same year. Currently agencies have no way of determining if a patient has been served by another agency during the same year. Implementation of the provision will require significant tracking efforts by home health agencies and by HCFA, and will be made more difficult by the fact that agencies have different limits and different fiscal years. Further, proration of the limits discourages agencies from taking patients that have been served by other agencies and interferes with a patient's right to choose the agency from which care will be received. HCFA has not yet implemented the proration policy.

Recommendation: Congress should amend BBA to require that HCFA only use the proration provision in cases where an agency has transferred or prematurely discharged a patient in order to circumvent the payment limits. Congress should also prohibit retroactive application of the proration policy.

IV. HCFA Initiated Regulatory Burdens on Home Care Providers

D. Congress should provide relief from a number of regulatory burdens initiated by HCFA. These changes should have little or no budgetary impact.

1. *Home Health Advance Beneficiary Notice.* HCFA recently issued Transmittal No. A–99–38, which sets out significant new instructions and requirements regarding home health advance beneficiary notices (HHABN). These notices must be provided by agencies to beneficiaries when care is ordered by a physician but determined by the agency to not be covered by Medicare. HCFA failed to follow legal requirements, such as the Administrative Procedures Act and the Paperwork Reduction Act, in issuing this new directive, and now has asked for emergency clearance by the Office of Management and Budget (OMB) so that the requirement may be implemented September 30. The timeframe for implementation of the requirement is inadequate, as the changes require home health agencies to update computer programs and information systems and create and reproduce forms, as well as train employees in the new notice requirement. Language experts have reviewed the notices and found them to be ambiguous and difficult to comprehend, increasing the likelihood of beneficiaries' confusion. While the home health community supports the general purpose of the new notices, the way they are written and the timeframe for implementation pose serious problems to beneficiaries and home care providers.

Recommendation: Congress should direct HCFA to withdraw the transmittal and implement a new beneficiary notice requirement only after the content of the notices has been reviewed by consumer and provider groups. Subsequent release and implementation of the HHABN should occur within a reasonable timeframe enabling agencies to comply.

2. *Outcome and Assessment Information Set (OASIS).* OASIS data collection and reporting is important to agency efforts to improve quality of care and to HCFA efforts to develop and refine the forthcoming home health PPS. OASIS data collection and reporting adds substantially to visit time, caregiver responsibilities, and administrative overhead. Among the problems related to the OASIS requirements are the following: 1.) HCFA intends to require collection and reporting on all home health clients, regardless of payer or health status; and 2.) HCFA has failed to provide adequate reimbursement to agencies for the significant costs associated with start-up and ongoing OASIS collection and reporting. The small reimbursement level allowed by HCFA is $0.13 per visit, and is only available to agencies that have not exceeded the per-beneficiary limit. As the result, only about 30 percent of agencies will be eligible for any reimbursement. Agencies have reported that OASIS costs amount to between $1 and $3 per visit.

Recommendation: Congress should direct HCFA to limit OASIS data collection and reporting to Medicare and Medicaid patients in need of intermittent skilled care. Additional study should be conducted to support the uses and usefulness of such data before HCFA considers mandating collection and transmission of OASIS data for private pay patients receiving skilled care or for any patients receiving personal care. Congress and HCFA should provide for reimbursement of the full costs associated with meeting OASIS requirements. HCFA should be directed to conduct further study regarding costs of OASIS and adapt its reimbursement structure to reflect the costs agencies are incurring. Home health PPS rates should reflect fully the costs of OASIS.

3. *Branch Offices.* HCFA's central office has established new guidelines for regional offices to consider when approving branch offices. These guidelines include limiting driving time to one hour or not more than 50 miles from a parent agency which require daily on-site supervision of the branch office. HCFA's regional offices have been strictly interpreting and implementing these guidelines. This strict interpretation has created financial and operational hardship for many branch agencies, especially rural home care providers. Furthermore, branch agencies who are more than an hour away from their parent agency must establish a new subunit with a new Medicare provider number, undergo new Medicare certification, and hire new supervisory staff. Branch offices are a cost effective way to provide a home base for staff closer to the patients served while avoiding duplication of administrative positions and functions. HCFA's branch office policies differ from one region to another. These guidelines do not recognize home health staffing shortages or the use of modern methods of communication, including fax, telephone, pagers, and other telecommunications.

Recommendation: Congress should direct HCFA to institute a new rulemaking procedure to establish a single set of national criteria for defining "branch office" under the Medicare home health program.

4. *Statistical Sampling Methodology for Post-Payment Review.* HCFA's fiscal intermediaries review a small sample of agencies' claims for a period of time for medical

necessity, then project the number of denied claims to the entire universe of an agency's claims. The intermediary then charges the agency to either return payments for the claims presumed to be denied, or submit to a 100% review of claims for the specified period. Agencies are required to repay the amount before having the opportunity to pursue legal appeal rights, despite the fact that reversals of claim denials on appeal have routinely exceeded 80%. Some of HCFA's own staff have protested the use of statistical sampling as invalid and irresponsible.

Recommendation: Congress should direct HCFA to suspend fiscal intermediaries' use of statistical sampling for home health claims until appropriate modifications are made in policy.

5. *Medical Claims Review.* Home health agencies are being subjected to increasing inappropriate and excessive random and focused medical reviews, medical review inconsistencies, and technical denials. As the result, thousands of Medicare claims are currently in dispute or on appeal, creating severe cash flow problems for many providers.

Recommendation: Congress should direct HCFA to: establish minimum standards and training requirements for medical review staff; implement a systematic yet fair process for review of a minimum sampling of records and appropriately targeting problem agencies for in-depth review; allow for return of claims that fail review on technical grounds so that a provider may correct the claim, rather than outright rejection of the claim; initiate performance reviews of all intermediaries on an ongoing basis; evaluate local medical review policies on an ongoing basis; and assess medical review workloads of the intermediaries and their effect on consistency and quality.

Conclusion

Thank you, Mr. Chairman, and Members of the Subcommittee, for the opportunity to present our views. We urge you, on behalf of home health patients and providers nationwide, to pass legislation this year eliminating the 15% payment reduction. Other BBA refinements, as outlined in our written testimony, will go far in alleviating the financial and operational burdens confronting home health providers. You and the Subcommittee have our thanks for bringing home health issues to this level of consideration. We look forward to working closely with you as you move toward refining some aspects of the Medicare home care provisions of BBA.

Statement of National Association of Psychiatric Health Systems

The National Association of Psychiatric Health Systems (NAPHS) is pleased to submit a statement for the hearing record addressing Medicare Balanced Budget Act refinements. NAPHS represents behavioral healthcare systems that are committed to the delivery of responsive, accountable, and clinically effective treatment and prevention programs for people with mental and substance abuse disorders. Its members are behavioral healthcare provider organizations, including 400 specialty hospitals, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, partial hospital services, behavioral group practices, and other providers of care.

We urge the subcommittee to include in its Medicare package this year the provisions in H.R. 1006, the Medicare Psychiatric Hospital Prospective Payment System Act of 1999 introduced by Reps. Jim McCrery (R–LA) and Ben Cardin (D–MD). H.R. 1006 proposes to improve Medicare inpatient psychiatric care by reforming how Medicare pays for services provided in free-standing psychiatric hospitals and distinct-part psychiatric units of general hospitals. Specifically, H.R. 1006 would move reimbursement for psychiatric facilities to a prospective payment system (PPS) within two years, while phasing in payment cuts required in the Balanced Budget Act of 1997 (BBA) over the same period.

Passage of the McCrery-Cardin PPS legislation would bring reimbursement for this specialty group in line with reimbursement systems for other TEFRA providers and would help to ensure that the sudden and severe cuts imposed by the BBA on psychiatric providers do not compromise patient care.

As a result of the BBA, 84% of psychiatric facilities that are exempted from Medicare's prospective payment system suffered actual payment reductions in 1998 compared to 1997, not merely reductions in their growth rate or annual update. These reductions compound their already negative Medicare margins. The mean average profit margin declined from −3.0% in 1995 to −8.7% under the BBA. In addition,

6% of facilities experienced cuts of over 20%.[1] Moreover, the impact does not include the first-year effect of a 15% reduction in capital payments and a 25% reduction in bad debt payments, also enacted as part of the BBA.

H.R. 1006 would phase-in cuts required in the BBA, to be paid back within a prospective payment system. The purpose of H.R. 1006 is to ensure that those psychiatric facilities hardest hit by the BBA cuts are given a reasonable time period to adjust financially to the payment limits of the BBA while contributing to the BBA's Medicare savings goals.

H.R. 1006 is budget neutral over four years. Whatever Medicare savings are foregone (as estimated by the Congressional Budget Office) as a result of the short-term payment relief will be re-captured in the first two years of the PPS, through an adjustment to the PPS rates.

NAPHS believes it is time for psychiatric facilities to join other providers in the Medicare program that are paid on a prospective basis, but patient care in the interim should not be put at risk.

Thank you for the opportunity to present our views. Again, we ask the Subcommittee to include H.R. 1006 in a larger Medicare bill aimed at addressing BBA issues. It is a fair and reasonable proposal that deserves full Congressional support.

Statement of National Rural Health Association

A real and imminent crisis is occurring in our country that threatens to shutout a vast number of our citizens from receiving health care as many rural and frontier providers are teetering on the brink of reducing and eliminating essential services. In that light, the National Rural Health Association (NRHA) would like to share its support for the rural targeted Balanced Budget Act of 1997 (BBA) relief priorities identified by our diverse, grassroots membership. We believe that collectively these priorities will secure access to vital health care services for rural Medicare and Medicaid beneficiaries and their families.

A report authored by the non-partisan Rural Policy Research Institute states, "Given low enrollment into managed care and limited use of any Medicare risk plans in rural areas for the foreseeable future, the impact of changes in traditional Medicare are of vital concern for the welfare of rural beneficiaries." Without rural targeted BBA reforms, the NRHA is gravely concerned that access to basic health care services will be jeopardized for those seniors living in rural and frontier America.

Recognizing the need for rural targeted BBA relief, both the House Rural Health Care Coalition and the Senate Rural Health Caucus introduced omnibus rural health care bills earlier this year, H.R. 1344 and S. 980, which include a number of important BBA relief provisions. Currently 95 members of the House of Representatives and 31 members of the Senate have cosponsored these rural health bills—a clear indication of the bipartisan support for rural targeted BBA relief. The NRHA's BBA relief priorities were taken directly from provisions included in both H.R. 1344 and S. 980, and are supported by both the House Rural Health Care Coalition and the Senate Rural Health Caucus.

In a recent letter to the Congress, thirty-nine of our nation's state office of rural health directors shared, "Over the past 10 years state and federal programs have encouraged our rural health providers to integrate their services. For many rural communities, it is the hospital that provides not only inpatient and outpatient care, but also services such as skilled nursing, home health and ambulatory care. Because the BBA reduces payments in each of these areas, rural hospitals are being financially punished for having done exactly what state and federal governments asked them to do—integrate services. As a result, these hospitals are reducing and eliminating services that rural beneficiaries and their families depend on daily."

If the BBA is fully implemented and rural hospitals, clinics and health centers are forced to reduce services or in some instances, close their doors, hard-to-recruit physicians and other health care providers will leave these communities. To reopen a rural health clinic or to recruit a primary care practitioner back into a rural or frontier community is an almost impossible task. That is why the Ways and Means Health Subcommittee and the Congress must be proactive in ensuring access to health care is not jeopardized for rural Americans.

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[1] These and other data were the findings of a March 1998 study conducted by Health Economics Research for the National Association of Psychiatric Health Systems on the impact of the BBA changes on psychiatric facilities.

Data from the Medicare Payment Advisory Commission illustrates that a greater percentage of rural hospitals experienced negative total Medicare operating margins in fiscal year 1995 than urban hospitals −15.9 percent vs. 9.8 percent. Of concern to the NRHA is that these numbers reflect the financial condition of small, rural hospitals before any portion of the payment reductions in the BBA had been enacted and implemented.

The fact is rural hospitals and other providers depend more on Medicare reimbursement than their urban counterparts and are more vulnerable to payment reforms and reductions under the BBA, because rural America has a disproportionately higher percentage of Medicare beneficiaries. BBA relief targeted toward rural health care providers must be enacted this year so these providers can continue to ensure access to quality health care for the millions of Medicare and Medicaid beneficiaries living in rural and frontier America.

Of equal concern is the Congressional Budget Office has projected that Medicare spending for fiscal year 1999 will be $88.5 billion less than was anticipated when the BBA was enacted. The result is our nation's rural hospitals, community health centers, rural health clinics and other providers are being asked to provide rural Medicare and Medicaid beneficiaries with a greater number of health care services and higher quality of care while their Medicare and Medicaid payments are being drastically reduced beyond what the Congress originally intended.

Because of the cumulative negative impact that reforms contained in the BBA are beginning to have on the rural health care delivery system, *it is imperative that the rural targeted priorities outlined below be included in any BBA relief measure considered by your Subcommittee and the Congress this year.* The NRHA stands ready to assist and support the Ways and Means Health Subcommittee and the Congress in guaranteeing access to health care services for rural and frontier Americans. If you have questions about the NRHA's BBA relief priorities or if the association and its membership can be of further assistance to you, please contact Darin E. Johnson, Vice President for Policy and Public Affairs, at (202) 232–6200.

The National Rural Health Association's Rural Targeted BBA Relief Priorities

1. Medicare Hospital Outpatient Prospective Payment System

Exempt Medicare Dependent Small Rural Hospitals and Sole Community Hospitals from the proposed Medicare hospital outpatient PPS system or at a minimum, establish a stop loss measure to protect low-volume, rural providers from the disproportionate effects of the PPS system.

The NRHA is deeply concerned with the Health Care Financing Administration's (HCFA) proposed rule implementing a Medicare prospective payment system (PPS) for hospital outpatient services as defined by the BBA New estimates prepared by HCFA demonstrate the grave impact the proposed PPS system will have on low-volume, rural hospitals.

The NRHA understands Congress may be considering, as part of a larger BBA relief measure, a phase-in of the proposed PPS payment methodology as a means of protecting small, rural hospitals from the severe impact of the proposed PPS system. *The NRHA strongly opposes a phase-in because the impact on rural hospitals will ultimately be the same—small, rural hospitals will be placed in a financially vulnerable situation.* A phase-in of the PPS system for hospital outpatient services would be nothing more than a band-aid fix to a very serious problem which merits a more viable and long-term solution.

HCFA's latest analysis on the impact of the proposed PPS system shows that Medicare payments for hospital outpatient services for small, rural hospitals with fewer than 50 beds would be reduced by 13.8 percent compared to 5.7 percent for all hospitals. In addition, total Medicare payments on average for rural hospitals would be reduced almost twice as much as for all hospitals (1.1 to 0.6 percent). The harsh reality is that access to care for Medicare beneficiaries in rural areas will be jeopardized as a result of this proposed PPS methodology, especially when combined with other payment reductions included in the BBA.

For some rural hospitals (25–100 beds), outpatient services total 45 percent of total revenue compared to less than 33 percent for their urban counterparts. Many of these hospitals already are experiencing negative operating margins, making them extremely vulnerable to the effects of outpatient payment reform. It appears the effect is greater on government owned hospitals and hospitals with less than 50 beds. It is these hospitals that are providing services to the most remote areas of our nation, and also generally serve communities with high Medicare populations.

2. Medicaid Reimbursement to Community Health Centers and Rural Health Clinics

Repeal the phase-out of Medicaid cost-based reimbursement to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) or as an alternative, implement a prospective payment system that guarantees rural centers and clinics receive equitable reimbursement.

Beginning October 1, 1999 the BBA permits state Medicaid agencies to pay FQHCs and RHCs less than it actually costs the rural health care provider to care for their Medicaid patients. Moreover, the phase-out methodology used by the BBA is flawed in that it automatically reduces reimbursement below the cost of providing services no matter how reasonable they may be. Such a drastic move will threaten the existence of these safety net providers and the role they play in ensuring access to quality health care for rural Medicaid and Medicare beneficiaries and the uninsured.

FQHCs and RHCs provide primary care services to our nation's most vulnerable and underserved rural populations. As a result, these providers are extremely dependent upon Medicaid payments to cover the cost of these services. The BBA forces community health centers to face revenue losses that are impossible to avoid or overcome through greater efficiencies or cost-cutting. In the year 2000 alone, these revenue losses will equal $100 million nationally.

According to the HCFA's own analysis, the Medicaid per beneficiary cost is much lower in a RHC than in other provider settings by an average of $500 per beneficiary. Such a reduction in Medicaid reimbursement penalizes RHCs for their efficiency in providing primary care services to rural Medicaid beneficiaries.

The House Rural Health Care Coalition's Triple-A Rural Health Improvement Act of 1999 (H.R. 1344) repeals the BBA's provision phasing-out reasonable cost reimbursement to FQHCs and RHCs. The Senate Rural Health Caucus' Promoting Health in Rural Areas Act of 1999 (S. 980) and two free-standing bills (S. 1277 and H.R. 2341) create an alternative Medicaid PPS system for FQHCs and RHCs.

The PPS system provides Medicaid payments in fiscal year 2000 that are equal to 100 percent of the per visit costs of furnishing services in 1999. Subsequent to 2000, the amount per visit would be increased by the percentage increase in the Medical Economic Index and adjusted for changes in scope of services. The Senate provision would also allow states to pay for services at rates above those provided by the Medicaid PPS system. *The NRHA would support an alternative Medicaid PPS system if it is modified to reward cost efficient FQHCs and RHCs and contains a federal enhanced match to encourage states to continue paying cost-based reimbursement to these essential providers.*

3. Health Professional Shortage Area and Medically Underserved Area Designations

Legislate the following as the Bureau of Primary Health Care (BPHC) considers changes to the methodologies used to define Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs):

- Require consideration of pending physician retirements or resignations in designating HPSAs;
- Require revised standards for HPSA designation through expedited negotiated rule-making process;
- Require DHHS to consider the needs of medically underserved populations and individuals and the percentage of the population over age 65 in developing such standards; and
- Prohibit new methodology for HPSA designation if the methodology is detrimental to rural or frontier communities in that it results in the provision of fewer services.

Given the dramatic impact the BPHC's proposed rule to establish a new designation methodology for Medically Underserved Populations (MUPs) and HPSAs would have had on federal and state programs to serve rural and frontier underserved populations, the BPHC was recently forced to withdraw its proposed revision to the methodology for designating these areas.

While the current law establishing MUAs and HPSAs applies specifically to the National Health Service Corps and Federally Qualified Health Centers programs, a number of other important programs impacting underserved populations are affected by these designations. Federal programs impacted by changes in the designation methodology include eligibility for cost-based reimbursement to Rural Health Clinics, allocation of Health Professions Education and Training Grant programs (Titles VII and VIII) funding, Indian Health Professions Scholarship Grant program, Medicare bonus payments to physicians in underserved areas and eligibility for Medicare telehealth reimbursement. It is critically important to take into consideration the implication of any change in the MUA and HPSA methodologies on these

programs, as well as state sponsored programs. The smallest change in these methodologies could put in jeopardy a number of federal and state programs and resources providing access to primary care services.

The BPHC's proposed methodology did not give considerable weight to the additional needs of the nation's elderly and Medicare population, a disproportionate number of whom reside in rural and frontier communities. While the proposed rule included a method for age-adjusting, several states reported that under the proposed methodology areas with higher percentages of elderly residents actually were disadvantaged. Any final underserved area designation must give separate consideration to the elderly population.

Additionally, the proposed designation did not take into account the special needs and characteristics of our nation's frontier population. It was likely that a number of frontier areas would not have met the requirements to be designated as a MUP, and therefore would not have been designated as a HPSA even though their population to primary care practitioner ratio was greater than 3000 to 1. The NRHA recommended in its formal comments to the BPHC that a separate frontier area designation process be established to take into account population density, distance in miles to the nearest service market and time in minutes to the nearest service market.

Given the many barriers to health care services the proposed MUA and HPSA designation methodology may have caused rural and frontier underserved areas, the Congress must direct the BPHC to initiate a negotiated rule-making process to facilitate the design of a new underserved designation that more appropriately and effectively recognizes medically underserved and health professional shortages areas in rural, frontier and urban areas.

4. Critical Access Hospital Reforms

Strengthen the Medicare Rural Hospital Flexibility Program by making the following important reforms to this program which is maintaining essential access to basic hospital and emergency room services for rural and frontier Americans:

- Allow hospitals that closed or downsized to a clinic within three years of enactment of this law to reopen as or convert to a Critical Access Hospital (CAH);
- Allow CAHs to choose between two options for payment for outpatient services: (1) reasonable costs for facility services, or (2) an all-inclusive rate which combines facility and professional services;
- Require Medicaid programs to reimburse for services in CAHs;
- Change the 96 hour length of stay limit to a 96 hour average;
- Exempt CAH swing beds from PPS for skilled nursing facilities; and
- Grant CAHs deemed status that will allow for accreditation.

The NRHA urges the Congress to adopt reforms to the Medicare Rural Hospital Flexibility program that will further strengthen our nation's rural health care delivery system. This program, established by the BBA, creates an important alternative for small, rural hospitals by providing regulatory relief and more equitable financing options by assisting states in proactively responding to market changes, removing restrictive regulatory standards, and supporting network development and regional approaches to health care. It is vitally important the Subcommittee include the NRHA's CAH reforms in its BBA relief legislation so this program is able to reach its full potential.

To date, 36 state rural health plans have been approved by HCFA, and approximately half of the estimated 1,100 eligible small, rural hospitals nation-wide have indicated an interest in being designated a CAH.

Extremely crucial to encouraging maximum participation in the program is allowing CAHs to choose between two options for payment for outpatient services: (1) reasonable costs for facility services, or (2) an all-inclusive rate which combines facility and professional services. The all-inclusive payment allows hospitals to bundle physician payments into their CAH cost-based reimbursement, which is a key financial incentive to recruiting physicians to practice in CAHs. This option was an important component of the successful demonstration projects that this program is based upon—the Montana Medical Assistance Facility program and the Essential Access Critical Hospitals/Rural Primary Care Hospital program.

Permitting hospitals that have recently closed or downsized to reopen or convert to a CAH is also vital to the ultimate success of the program. This provision would allow those facilities that have already succumbed to the overwhelming financial pressures created by decreasing Medicare and Medicaid reimbursement payments to continue providing essential primary and emergency care services to their communities. Changing the current 96 hour length of stay limitation to a 96 hour average will also provide CAHs flexibility in caring for their patients. In addition, it will

save money from unnecessary and costly patient transfers when only an additional day or two of inpatient care is needed.

5. National Health Service Corps Scholarships

Exempt the National Health Service Corps (NHSC) scholarships from federal taxation in any tax measure that moves through the Congress this year.

This tax provision was included in the tax measure recently approved by the Congress, but subsequently vetoed by the President. It was also part of a broader education bill passed last year that was again vetoed by the President because of unrelated provisions. As demonstrated by its passage by the Congress on two occasions, wide bipartisan and bicameral support for this issue exists—which is vital to the NHSC's mission of providing quality health care services to our nation's most vulnerable populations.

In testimony submitted earlier this year to the House Ways and Means Committee, a NHSC scholar and second year medical student spoke of how she was forced to take out two loans—one to cover a portion of her living expenses and the other to pay her federal taxes—because each month more than half of her stipend is withheld by the Internal Revenue Service (IRS) for tax purposes.

The NHSC program plays a critical role in providing primary health care services to rural and urban underserved populations. The scholarship program is one of the few incentives the NHSC has to recruit new clinicians to rural and inner-city communities. Currently 2,400 NHSC clinicians, including physicians, dentists, nurse practitioners, physician assistants, nurse midwives, and mental and behavioral professionals, provide primary care services to over 4.6 million Americans who would otherwise lack access to quality health care.

6. Rural Impact Statements

Require the Department of Health and Human Services (DHHS), when promulgating or proposing a regulation related to a health care program, to include an analysis of the impact of implementation of the regulation on rural areas, including its impact on: (1) rural safety net providers; (2) rural primary care providers; (3) rural hospitals; (4) FQHCs and RHCs; (5) the economies in rural areas; and (6) rural residents.

While the NRHA recognizes the enormous burden that has been placed upon the DHHS, specifically HCFA, as it implements the Medicare and Medicaid reforms contained in the BBA, the association remains extremely concerned that the Department continues to consider, draft and implement policies that will put access to health care in jeopardy for rural beneficiaries. *Recent regulations proposed and implemented by HCFA have not recognized the unique needs of our nation's rural health care delivery system.*

On several occasions the BBA and members of the Senate Finance Committee and the House Ways and Means Committee were explicit in their intent to give special considerations to rural providers when implementing portions of the BBA. For example, the BBA gave specific instructions to the Secretary of HHS to give "special considerations" to rural residency programs when apply the BBA's Graduate Medical Education reforms. These special considerations were not included in the Department's final rule. On another occasion, members of the Senate Finance Committee responsible for drafting the telehealth portion of the BBA communicated that it was their intent that "store and forward" telemedicine be reimbursed by Medicare—yet the Department refused to follow these instructions. Most recently HCFA's own analysis shows that its proposed PPS system for Medicare hospital outpatient services will have a disproportionate impact on low-volume rural hospitals. However, the Administration recently proposed in its fiscal year 2000 budget to move forward with applying the PPS system to small, rural hospitals with a transition period.

Given these reoccurring examples of how the interests of rural health care providers and beneficiaries are not being taken into consideration by the DHHS as important policies are developed, it is critical that Congress mandate that the implication of policies and rules on the rural health care delivery system be analyzed and receive the serious consideration they deserve by the Department.

7. Graduate Medical Education Reforms

Legislate the following rural Graduate Medical Education reforms to promote residency opportunities in rural and frontier communities:

• Require the Department of Health and Human Services to provide special consideration in apply the BBA provisions that reduced IME payments to providers and placed a ceiling on the number of Medicare funded residencies to rural residency

programs, as well as facilities that are not located in an underserved rural area but have established separately accredited rural training tracks;

- Increase indirect GME payments to some hospitals by changing the way interns and residents are counted, from including those who were in the hospital during the most recent cost reporting period ending on or before December 31, 1996, to those who were appointed by the hospital's medical residency training programs for the same time period; and
- Allow a hospital that sponsors only one residency program to count one additional intern/resident for each calendar year up to a maximum of three more than the limit otherwise determined under this provision.

The BBA contained several Medicare GME provisions that were intended to promote residency opportunities in rural hospitals and ambulatory settings. The provisions were included by Congress because studies show that GME programs located in rural areas help to counteract persisting rural physician shortages by attracting medical residents and physicians to rural communities. Unfortunately, these rural specific GME provisions were not implemented by the Secretary of HHS in her final rule implementing the BBA.

The BBA called for the gradual reduction of IME payments to facilities training residents, and a ceiling to be phased-in on the number of residents for which a GME program will receive Medicare funding. For the purpose of determining both IME and DME payments, existing programs may not exceed the number of resident FTEs reported in their teaching hospital on or before December 31, 1996.

Understanding the cap on the number of residents would restrict new and expanded residency programs in general, the BBA recognized the importance of graduate medical training in rural areas by instructing the Secretary of HHS to "give special consideration to facilities that meet the needs of underserved rural areas." In addition, the Secretary was also given discretion to modify the ceiling for new GME programs (those established on or after January 1, 1995). *Despite the Congress' explicit guidance, the Secretary did not make any special considerations for facilities providing rural and frontier residency opportunities in her final rule implementing the GME provisions.*

8. Wage Indices for Skilled Nursing Facilities and Home Health Agencies

Require that area wage adjustments for the skilled nursing and home health care PPS systems be based on wage levels at Skilled Nursing Facilities and Home Health Agencies.

As part of the current Medicare hospital inpatient PPS system, HCFA uses a complex formula to determine the amount it reimburses hospitals for providing inpatient services to Medicare beneficiaries. About three-quarters of that payment is increased or decreased by applying a hospital wage index which is intended to adjust for the fact that market wage rates for nurses and other hospital employees vary somewhat across the country.

The current index actually goes well beyond its original intent in that it not only makes adjustments for differences in local wage rates, but it also rewards hospitals in areas, mostly urban, where a greater than average number of employees are hired. As a result of this methodology, the wage index varies greatly between urban and rural hospitals—the primary reason Medicare reimbursement to rural hospitals is lower and their resulting Medicare inpatient margins are less than half of urban hospitals (4.4 versus 9.7 percent in 1995).

The BBA mandated that HCFA develop new PPS systems for hospital outpatient services, skilled nursing and home health care. HCFA has signaled that it plans to apply the currently flawed wage index, which was created specifically for the hospital inpatient PPS system, to the payment systems for hospital outpatient services, home health care, and skilled nursing. The NRHA believes only wage rates relevant to the specific services providing in these settings should be used. In addition, the hospital wage index, as well as the wage indices used by the new PPS systems for hospital outpatient services, home health care and skilled nursing, should be changed to reflect only legitimate differences in area wage rates, not average per employee expenditures that are biased toward facilities in urban areas.

9. Medicare Rural Waiver

For purposes of Medicare payments, establish a waiver process to allow rural providers located in Metropolitan Statistical Areas (MSAs) to be classified as "rural" if they are located: (1) in a rural area as defined by the Goldsmith Modification published in the Federal Register on February 27, 1992; (2) outside of an urbanized area as defined by the U.S. Census Bureau; or (3) in an area designated by a State as rural.

The definition of a rural area currently used by HCFA for purposes of Medicare reimbursement does not recognize certain hospitals and other providers that are indeed located in rural and frontier areas. Because the federal definition of rural is based solely on whole-county urban or rural classification, some rural hospitals, community health centers and rural health clinics cannot participate in Medicare programs designed to help preserve access to care for rural Medicare beneficiaries and their families. These important programs include the Medicare Rural Hospital Flexibility/Critical Access Hospital program, the Medicare Dependent Hospital and Sole Community Hospital programs and the Rural Health Clinics program. The supplemental payments made to rural providers by these programs are frequently the primary reason for their continued viability and existence.

As defined by law, the Medicare program currently defines "rural" as any area that is outside of a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget. MSAs are defined along county lines and may include one or more counties. This definition ignores such important factors as geography, demography, transportation, and economics in defining rural and urban areas.

For purposes of determining eligibility for federal grant programs, the Federal Office of Rural Health Policy uses the Census Bureau's rural census tracts which recognize rural areas within MSA counties. In addition, both the Department of Agriculture and the Federal Communications Commission have adopted this rural definition for their rural-focused programs. Rural hospitals, health centers and clinics that are currently located in MSA counties do not have the ability to obtain reclassification from urban to rural status.

Statement of Organizations of Academic Family Medicine

Dear Mr. Chairman: The Organizations of Academic Family Medicine, on behalf of faculty, researchers, program directors, and chairs of departments of family medicine, appreciate the opportunity to provide input to this Committee in its current deliberations over the Balanced Budget Act (BBA) of 1997. You have heard from some major sectors of the provider community regarding problems or untoward effects of the BBA. We would like to address a small, but critically important piece of the BBA that has had an unintended consequence of disproportionately harming training of one specialty in particular, family practice.

The Balanced Budget Act of 1997 (BBA) was intended, in part, to remove statutory impediments to ambulatory, non-hospital based training. Although we support the intent of the provisions of the BBA, the reality of how they function has been detrimental to ambulatory training, particularly family medicine residencies, the very ones that historically have conducted ambulatory training. Implementation of the BBA also does not support production of rural physicians in a way that would be in keeping with the intent of the statute.

Changes in the BBA Disproportionately Harm Production of Family Physicians

Although ostensibly the BBA is supposed to have leveled the playing field and removed disincentives to ambulatory training, we find it to be just the opposite for family medicine graduate training. Many believe that the recent changes to Medicare graduate medical education funding (as passed in the Balanced Budget Act (BBA) of 1997), such as the capping of residency slots, will help reduce the nation's total production of physicians, while protecting the production of physicians who serve in rural areas. Unfortunately, this is not the case.

While we wholeheartedly support the intent of the statutory changes, their implementation has had two unintended consequences: (1) penalizing family practice programs that have historically sent residents for training in non-hospital settings, including rural site rotations, while promoting such training for other specialties, and (2) restricting the growth of family practice programs, when 21 percent of family physicians serve in rural areas. Moreover, implementation of the BBA has prohibited payment of graduate medical education funds in the future to newly established, separately accredited rural training tracks. These programs, which of necessity are sponsored by non-rural institutions, have proven track records of producing graduates to serve in rural areas. These consequences are especially troubling since Congress intended support for production of rural physicians.

BBA Causes Reductions in Both Programs and Residents in Family Practice

The Association of Family Practice Residency Directors (AFPRD) surveyed family practice residencies earlier this year. The evidence that family practice programs have been hurt by the BBA is compelling. Overall, 10 percent of programs have been told by their sponsoring institutions to decrease their number of residents (45 programs). Twenty-three percent have been told that it would be likely that they would be asked to reduce their number of residents in the future. Eleven percent have plans to increase the number of residents. In addition, the ACGME reports eleven programs have begun the process of closing down (since August, 1997), and two more have just announced their closure. Three of the thirteen programs that have closed or are closing are rural tracks. These figures do not include those closing due to mergers.

It is important to note that this is the first year that programs have reduced their number of residents. There had been a net increase of 11 to 12 programs per year, between '90 and '97. Family practice residencies expanded by approximately 18–22½ percent during that time, from 380 programs to 470. Typically, 1 to 2 programs close each year. Thirteen programs closing in the three years since the BBA was passed is unusually high.

Rural Programs Harmed, in Spite of Unqualified Success

The impact is especially telling when one looks at rural training tracks. Not only have 20 percent of rural tracks stated that they plan to decrease their number of residents, but the BBA does not allow payment of GME funds to newly established training tracks.

Among the 474 family medicine residency programs in this country, 29 have made special provision to train family physicians for rural practice. They have established separately accredited rural training tracks. Our organizations recently collected information from these programs regarding the practice location of each program's graduates. (Data was unavailable from 7 programs—1 had closed, 5 were too new to have had any graduates yet, and 1 did not respond to our request for information.)

These programs are a true success story. Over half of the programs had a 100 percent retention of graduates in rural (non-MSA) areas. Overall, 76.0 percent (136 of 179) of the graduated residents were serving rural communities, the majority of those in the state of residency training. Even more impressive, new programs had an even higher rate of success. Of programs begun within the last 10 years, 88 percent (94 of 107) of graduates provided care in a rural, non-MSA county.

This compelling data is even more striking when compared with the performance of other types of residency programs. According to the AAFP Center for Research in Family Practice and Primary Care, nationally, among all non-Federal allopathic family physicians actively providing patient care in 1997, 21.0 percent practiced in rural, non-MSA counties. For the other 2 primary care specialties, general internal medicine and pediatrics, the figures were much lower—just 8.0 percent and 7.4 percent in rural practice respectively.

What Can Be Done?

There is legislation on hand that would correct these problems with minimal cost to the Medicare program. In the House, H.R. 1222, introduced by Rep. Baldacci, and a companion bill, S. 541, in the Senate, (introduced by Senators Collins (ME) and Murkowski (AK)) address these concerns. Moreover, the content of these bills has been incorporated into both the House and Senate omnibus rural health bills (H.R. 1344 and S. 980)

These bills include technical legislative changes to alleviate some untoward effects of the Balanced Budget Act of 1997 that are beginning to have grave consequences for family medicine residency programs. As you know, the statute put in place hospital-specific caps on the numbers of full time equivalent residents Medicare would pay for under GME. It also finally allowed for the counting of residents who spend time training out of the hospital in ambulatory settings for the purposes of reimbursement by Medicare. The bill also directs the Secretary to give special consideration to facilities that meet the needs of underserved rural areas. These are all changes academic family medicine supports wholeheartedly.

Unfortunately the language used in the BBA to carry out these GME changes has created disproportionate harmful effects on family practice residencies. The bills would solve these problems by:

1. Recalculating the IME and DME caps based on the number of interns and residents who were appointed by the approved medical residency training programs for

FY 1996, whether they were being trained in the hospital or in the community. Currently only programs prospectively introducing ambulatory training will be allowed to have those positions supported by Medicare.

The impact has been disproportionately harmful to family practice programs because the hospitals in which they were located were not allowed to count the residents they had serving in community settings in the cap. Only family practice residents are trained extensively out of the hospital and only family practice residencies were significantly harmed by this provision in the BBA.

2. Changing the cut-off date for adjusting the DME funding cap to September 30, 1999. Approximately 10 family medicine programs were "in the pipeline" for ACGME accreditation at the time of passage of the BBA. We believe that very few programs other than these would also fall into this window, since family medicine was one of very few specialties that were in a growth cycle.

3. Expanding the exception to the funding caps to include programs with separately accredited rural training tracks even if the sponsoring hospital is not located in a rural area, and for residency programs which are the only one offered in a given hospital.

The inability to initiate rural training tracks affects only family practice residencies. While these rural tracks require separate accreditation, they are sponsored by an existing, non-rural program and not allowed to expand because of the resident caps. This inhibits the ability to respond to the need for family practitioners in rural areas. The average rural training track has four residents, two in each of the 2nd and 3rd years of training. Based on this, the number of residents that would be added with additional rural training tracks would be modest.

The ACGME has indicated that only approximately 300 programs exist nationally as single programs within hospitals. Of this number 191 are family practice programs. The rest are exceptions across specialties, and most are extremely small. All other programs of any specialty would be able to grow to meet community needs based on a diminution of other specialty slots within the 1996 cap on FTE's. The cost of the exclusion from the cap of the hospitals that sponsor only one family practice residency should be minimal. Most of the family practice programs are located in small community hospitals. The programs are smaller than the national average, and we believe they cannot expand a great deal because the infrastructure needed to support larger programs is not available. For example, nationally, the average size of a family practice program is 27 residents; the average size of those family practice programs that are the sole program in its hospital is just under 21 residents.

In conclusion, we are asking that as this committee puts together a package of "fixes" to the BBA of 1997, that you keep in mind the concerns we have raised in this statement. Changes in the BBA, which purportedly support training in the ambulatory setting, have had a negative effect on family medicine training programs, the very ones that historically have conducted ambulatory training. Implementation of the BBA also does not support production of rural physicians in a way that would be in keeping with the intent of the statute. We hope that the committee will choose to incorporate H.R. 1222, the GME technical amendments of 1999, into the "BBA fix" vehicle that will be passed, to correct these problems.

We appreciate the opportunity to provide input and hope that you can support this legislation as you deliberate.

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
September 30, 1999

The Honorable William M. Thomas
Chairman, Health Subcommittee
1136 Longworth HOB
Washington, DC 20515

DEAR MR. CHAIRMAN:

As you and the Health Subcommittee deliberate over possible Medicare refinement language to Balance Budget Act of 1997, I urge you to consider a proposal that will have an immediate and positive impact upon Medicare beneficiaries. This proposal will help ensure that seniors are not charged excessive coinsurance payments for hospital outpatient services provided under Medicare Part B.

The BBA strengthened Medicare for our nation's seniors in many ways. One of these improvements was to ensure that beneficiaries pay a true 20% coinsurance

payment for hospital outpatient services. However, beneficiaries are being charged 20% of the hospitals submitted charges, rather than 20% of the Medicare reimbursement rate which is a lower dollar amount. As a result, beneficiaries are paying as much as 50% of the total payment for services.

As you are aware, Section 4523 of the BBA intended to correct this problem through a gradual reduction in Medicare beneficiaries' outpatient coinsurance payments. Unfortunately, the Medicare Payment Advisory Commission has estimated that this phase-in period may take as long as 40 years. I do not believe Congress intended that it take 40 years to implement this policy to achieve fairness for our nation's Medicare beneficiaries. Our nation's Seniors should not have to continue to bear higher Medicare costs through high coinsurance payments and potential increases in Medigap insurance premiums.

I have enclosed a proposal for your consideration, the Senior Citizens' Hospital Outpatient Coinsurance Relief Act, which will ensure that Congress fulfills its promise of fairer, more equitable coinsurance for Medicare hospital outpatient services. This proposal will phase in the true 20% coinsurance over a four-year period.

I believe it is very important that we include this measure in any Medicare reform or BBA correction this year. I urge you to consider this proposal—we ow it to our senior citizens! Thank you for your consideration of this important issue.

Sincerely,

BOB RILEY
Member of Congress

DRAFT
Doc. #269669

106th CONGRESS

1st SESSION

S. XXXX

IN THE UNITED STATES SENATE

_____, 1999

[insert sponsors/cosponsors]

A BILL

To amend Section 1833 of the Social Security Act, 42 U.S.C. § 1395*l*, as amended by Section 4523 of the Balanced Budget Act of 1997, Pub. L. 105-33 (Aug. 5, 1997), to expedite phase-in of reductions of coinsurance payments to twenty percent of the total payment under the Prospective Payment System for Hospital Outpatient Department Services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled.

SECTION 1. SHORT TITLE.

This Act may be cited as "Senior Citizens' Hospital Outpatient Coinsurance Relief Act of 1999."

SECTION 2. ASSURING PROMPT PHASE-IN OF REDUCTIONS IN COINSURANCE PAYMENTS TO TWENTY PERCENT OF TOTAL.

(a) IN GENERAL.-- Section 1833(t)(3)(B)(i) of the Social Security Act, as amended by Section 4523 of the Balanced Budget Act of 1997, Pub. L. 105-33 (Aug. 5, 1997), 111 Stat. 446, (42 U.S.C. § 1395*l*(t)(3)(B)(i)) is amended by adding at the end thereof the following:

"The unadjusted copayment amount applicable to a covered OPD service (or group of such services) shall be as set forth in the preceding sentence for services furnished during 1999, and shall be as set forth in the preceding sentence, but not to exceed the following percentages of the amount determined under subparagraph (D), for services furnished during each of the

subsequent four years: (I) 35 percent for 2000; (II) 30 percent for 2001; (III) 25 percent for 2002; and (IV) 20 percent for 2003."

(b) CHANGES TO PROSPECTIVE PAYMENT SYSTEM.—The Secretary shall make such changes to the prospective payment system established under Section 1833(t) (42 U.S.C. § 1395*l*(t)) as are necessary to determine payment for services furnished during the years 1999 through 2003 in accordance with these amendments.

The Honorable William Thomas
Chairman, Subcommittee on Health
House Ways & Means Committee
U.S. House of Representatiaves
Washington, DC 20515

Dear Mr. Chairman:

We are writing to express our concern with an issue of utmost importance to senior Medicare beneficiaries. This is the problem of excessive overcharges of hospital outpatient beneficiary co-payments.

When it comes to most hospital outpatient services, Medicare beneficiaries pay significantly more than the usual 20% co-insurance that they assume they are being charged. In fact, in its March 1999 report to Congress, the Medicare Payment Advisory Commission (MEDPAC) reported that "beneficiaries are liable for nearly 50% of the total payment to hospitals for these services, compared with 20% for most other Medicare covered services."

The MEDPAC report also states that this disproportionate beneficiary share for hospital out-patient services stems from calculating coinsurance as 20% of the hospitals' charges, while the Medicare program share is calculated as the lesser of costs or charges net of the beneficiary co-payment. Since hospitals' charges are generally much higher than their costs, beneficiaries are responsible for a larger share for the total payment.

This is unfair public deception and an abuse of senior beneficiaries! This problem needs to be fixed immediately. Medicare beneficiaries are being unduly charged these excessive co-payment amounts. Even if beneficiaries have supplemental insurance, they are feeling the effects of rising double-digit rate increases as a result of these excessive charges. We are very concerned about this trend.

Congress has already acknowledged the inequity of this problem and attempted to correct it in the Balanced Budget Act of 1997 (BBA). That act includes a provision that, over time, would reduce the beneficiary co-payment by adjusting the shares of payment under the outpatient Prospective Payment System. However, the problem today is that this reduction of the co-payment amount to a true 20% could take decades to phase in completely. In some cases, it has been estimated that it will take 20 to 40 years to fully phase in. This is unacceptable. This co-insurance reduction should occur at a much faster rate than currently established under the BBA. In its report to Congress, MEDPAC agrees with this.

Attached is a draft bill that would have the effect of reducing the beneficiaries' co-payment to a true 20% over a four-year period. The bill would indeed provide faster relief to our senior Medicare beneficiaries. This bill is consistent with the original intent of Medicare in that beneficiaries would only share to the extent of 20% of the Medicare approved charges. It is also consistent with the intent of BBA '97 because it would reduce the co-payment share within a reasonable time.

We ask that you include this bill in any Medicare legislation that is advanced in Congress this year, and specifically request that you include this proposal in the Finance Committee package. This is a fair solution to all interested parties. It merely provides a permanent solution to a problem that Congress has long recognized.

Sincerely,

John J. Powell
Vice President for Government Relations
Seniors Coalition

Nona Bear Wegner
President
Council for Affordable Health Insurance

Robert C. Conover
President
Christian Senior Alliance

Jim Martin
President
60-Plus

Major General Richard D. Murray
USA (Ret.), President
National Association for Uniformed Services

Mike Zabco
Executive Director
TREA Senior Citizens League

Beau Boulter
Legislative Counsel
United Seniors Association

Kermit N. Richardson
National President
The National Grange

[An attachment is being retained in the Committee files.]

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